FIFTY-FOUR CONSECUTIVE OVARIOTOMIES

BUTLER-SMYTHE

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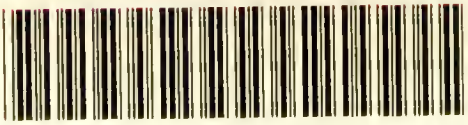

To C. J. Cullingworth Esq
with the Author's kindest
Regards and Thanks.
1876.

A FIRST SERIES OF FIFTY-FOUR CONSECUTIVE OVARIOTOMIES

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FIFTY-FOUR CONSECUTIVE OVARIOTOMIES

WITH FIFTY-THREE RECOVERIES

BY

A. C. BUTLER-SMYTHE, F.R.C.S. Ed., F.R.C.P. Ed.

SENIOR SURGEON TO THE GROSVENOR HOSPITAL FOR WOMEN AND CHILDREN; SENIOR SURGEON TO OUT-PATIENTS SAMARITAN FREE HOSPITAL FOR WOMEN AND CHILDREN

LONDON

J. & A. CHURCHILL

7 GREAT MARLBOROUGH STREET

1897

TO

SIR JOHN WILLIAMS, Bart.

M.D., F.R.C.P.

CONSULTING OBSTETRIC PHYSICIAN TO UNIVERSITY COLLEGE HOSPITAL

PHYSICIAN TO H.R.H. THE PRINCESS HENRY OF BATTENBERG, AND

PHYSICIAN ACCOUCHEUR TO H.R.H. THE DUCHESS OF YORK

EX-PRESIDENT OF THE OBSTETRICAL AND HARVEIAN SOCIETIES

IN

RECOGNITION OF THE GREAT SERVICES HE HAS

RENDERED TO HIS PROFESSION

AND

IN ACKNOWLEDGMENT OF MUCH PERSONAL KINDNESS

THROUGHOUT MY CAREER

I Dedicate this Volume

WITH EVERY SENTIMENT OF GRATITUDE AND ESTEEM

PREFACE

In publishing my "First Series of Fifty-four Consecutive Ovariotomies," I should not like it to be supposed that I am in any way influenced by a spirit of rivalry. The fact is simply this. When I had completed my first fifty cases I decided to wait and see if I could obtain a clear run of fifty successful operations, inasmuch as I had been unfortunate enough to lose my fourth patient.* Having now succeeded in attaining my object, I venture to publish the results.

I may, in passing, add that in the interval which has elapsed since the compilation of this record was first taken in hand, I have performed ovariotomy several times, and in each case have succeeded in saving my patient. For the present, however, I have decided to adhere to my original intention and to include in this publication only, as already stated, my first fifty-four consecutive ovariotomies.

In the concluding "Table of Cases," the after histories of the patients have been brought up to date as far as possible. A few, however, from one

* Particulars of this case will be found on p. 26.

cause or another have been lost sight of, and no trace of them beyond the given data has been discoverable.

I take this opportunity to express my indebtedness to my senior colleagues at the Samaritan Free Hospital, and more especially to Mr. W. A. Meredith, under whose tuition my early training in abdominal surgery was conducted and from whose example and instruction I have derived so many advantages. My sincere thanks are also due to my several colleagues at the Samaritan and Grosvenor Hospitals for Women for their kind assistance on all occasions.

Brook Street,
December, 1896.

A FIRST SERIES OF FIFTY-FOUR CONSECUTIVE OVARIOTOMIES

This little work is merely intended to be a record of all the ovariotomies performed by me up to the end of October 1895. Beyond some details of each case, and a few remarks relative to the methods employed in certain operations, together with a general outline of the after-treatment usually carried out in my practice, I fear there is very little to be gained by its perusal. Besides which, up-to-date works on abdominal surgery are now so plentiful that the latest doctrines are within the reach of every surgeon, and in these books the information given is not confined to the methods adopted by any operator in particular. Here let me state that in the following remarks I speak only of what has proved to be successful in my own work, and though some of the statements may seem to be directly opposed to the teachings of many authors, of much greater experience than myself, yet I hold by them, and shall continue to do so, until they are proved to be wrong in practice as well as in theory. Most of my operations have been performed in the Grosvenor and

Samaritan hospitals, the rest in private houses. Many of the cases have already been published in the medical journals and are here reproduced.

I frankly confess that the good results met with in this series of cases are mainly due to the strict observance of antiseptics, or rather, to the aseptic methods which are the outcome of Listerism, and which are now recognised as the most certain means by which a low rate of mortality can be assured in abdominal and all other operations. Little by little we have reluctantly discarded many of the details on which at first seemed to depend the success of our abdominal work. The sealing of wounds by carbolised putty; the carbolic spray; the toilet of the peritoneum by means of sponges impregnated with strong solutions of carbolic acid; the enormous masses of carbolic gauze dressings, which not only covered the wound but enveloped the abdomen also, have one by one been laid aside as irritating or unnecessary.

With the disuse of the spray the number of cases of bronchitis, carboluria, and hyperpyrexia diminished. The numerous folds of Lister's dressings have been replaced by a few layers of simple gauze, just sufficient to cover the abdominal wound. Lastly, the toilet of the peritoneum has been almost superseded by flushing out the peritoneal cavity with hot water at a temperature of 105° to 110°, with or without drainage, as the operator may decide.

The results of this simplification have been ex-

cellent, and the mortality has everywhere decreased. Still, it must never be forgotten that it is to Lister alone we owe the present almost perfect system of treating wounds. The methods adopted by the surgeons of the present day are but the natural evolution of the method originated by that great teacher. Aseptic surgery has proved beyond dispute that perfect cleanliness, before, at, and after an operation, is the one great essential for the welfare of the patient.

Time of Operation.—I prefer to operate at 9 A.M. for several reasons. The light is strong and bright; the patient is refreshed by a night's sleep; and I am beginning my day's work. Moreover, should secondary bleeding occur, or any further surgical interference be necessary, it is better to have to deal with such by daylight.

The Room in which the operation is to be performed must be well lighted, scrupulously clean, and far removed from any w.c. or bathroom. It should be large enough to contain two beds, a cupboard, washstand, two tables, and a couple of chairs. My usual habit is to have it thoroughly disinfected with sulphur before each operation.

Nothing in the way of eatables should be kept in the room, and if possible the nurse will have her meals elsewhere, as the smell of cooked food is objectionable to most sick persons.

The Nurse.—It is well to have a nurse who has had some experience in abdominal work, and better

still one who has been taught by the operator, and who understands his methods. She must be efficient with the catheter, and understand rectal feeding and the administration of enemas. Her notes should be concise and to the point. Implicit obedience is expected from my nurses, and though I am willing to devote any length of time to teaching them, I seldom overlook a second act of neglect or disobedience.

Preparation of the Patient.—As a rule, the patient is under observation for a few days previous to her operation, during which time special attention is directed to the alimentary canal, the kidneys, and the skin, and any errors corrected. She is put on a bland unstimulating diet, and kept quiet. The bowels are cleared out by castor oil, or some mild aperient, twenty-four hours before the operation, and early on the morning of the same an enema is administered. A cup of strong beef tea is given for breakfast, and nothing more is allowed, except in cases of great debility, when a little brandy and water is permitted. Immediately before entering the operating room, the urine is drawn off by a catheter. The patient is clad in a night-dress and bed-jacket, and wears warm stockings. When placed on the table, the knee-straps and wristlets must on no account be put on until she is under the influence of the anæsthetic; indeed, with nervous patients it is imperative that this should be administered in an adjoining room.

Instruments and Sponges. — No matter how experienced the assistant or nurse may be, the operator should always see to his own instruments if possible. It is better to have too many of them than too few; and experience tells me that to find one's self short of anything in the middle of a severe operation is worse than annoying. The number of sponges and forceps in use is always written down by me before an operation. Of forceps there should be at least two dozen. Fifteen sponges are my usual number—two flat, six large, six small, and one for my hands. These must all be counted by the operator and by the nurse before the operation, and again by the nurse aloud before the abdomen is closed, but she must understand that she should then only reckon those actually in her possession at the time, leaving it to the operator to make up the required number. By attending to this rule much trouble and annoyance may be avoided.

Anæsthesia.—The anæsthetist employed by me is responsible for every requisite in his department. Ether, or gas and ether, are almost invariably used at my operations. Curiously enough, on the only two occasions where chloroform was given, I very nearly lost my patients from syncope. I have witnessed several deaths from this anæsthetic, and frequently have seen cases where only the most energetic measures have been successful in averting a catastrophe. I regret to say that I never feel comfortable when giving chloroform, or when operating

on a patient under its influence. In my opinion ether is a much safer anæsthetic, and next to ether I prefer gas and ether, or the A.C.E. mixture.

Operation.—By the term ovariotomy I mean the removal of solid tumours of the ovary; cystomata; broad ligament tumours; parovarian, tubo-ovarian cysts, and cystic ovaries.

No distinct rules can be laid down for the performance of ovariotomy: each case must be treated on its merits; but there are one or two points which apply to cases where the tumour is adherent in front to the parietal peritoneum, and there is a difficulty in recognising the position of affairs. When the cyst is adherent in the line of incision, instead of then and there dissecting off the peritoneum, it is best to enlarge the wound upwards, when, in most instances, the operator will get well above the adherent portion, and the separation become easier.

In tapping an ovarian cyst, I much prefer to use a medium-sized trocar. I have noticed that when a large trocar is used, and the fluid evacuated rapidly, the patient is prone to become faint. It is bad surgery to attempt the removal of a large multilocular cyst through a small opening. The length of an incision is of little importance compared with the amount of pulling and handling necessary where the wound is small, besides which, the edges of the wound get bruised in vain attempts to extract the tumour. A long incision, carefully sewn up,

makes a stronger scar than a badly sewn small wound. Hernia through the cicatrix is not infrequently the result of undue haste in closing the wound, or of insufficientcare in placing the sutures. Broad pedicles are best treated with the "Wells" ligature, and it is a good plan to squeeze the pedicle with a large pressure forceps before tying the ligature. Bantock's knot is suited for all medium and narrow pedicles, and when properly tied I have never known it to slip.

Recent intestinal adhesions are best separated by free use of the sponge, but those of long standing should be carefully dissected off. Injury to the intestines must be at once treated by Lembert's suture. All deep adhesions should be tied if possible, as torsion is likely to tear them and allow of secondary hæmorrhage. If there be any resistance whilst the tumour is being extracted, the wound must be enlarged and the adhesions separated, but the cyst must on no account be forcibly dragged on. I have seen a coil of intestine torn through by not attending to this simple rule. If it can be avoided, the patient should not be put back to bed bleeding; the time spent in finding and securing the bleeding point may save the patient's life.

Before closing the abdomen the omentum must be drawn down over the intestines, and the forceps and sponges should be counted.

It has been my good fortune to perform several

operations in my own practice for enucleation of tumours burrowing in the broad ligament, and in addition to these I have assisted at a large number of such cases, my experience extending to over forty of these particular operations. In one of these the cyst arising in one broad ligament passed in front of the uterus, completely raising the peritoneum off that organ and separating the bladder from its front surface. In two others the tumours passed from one broad ligament behind the uterus, raising the peritoneum from its posterior surface and invading the opposite broad ligament. Such cases are exceptionally rare and are extremely difficult to deal with. It may be said in all truth that where a broad ligament tumour is diagnosed, the operator must be prepared for emergencies; and I should strongly advise the surgeon who tackles such cases to have plenty of sponges at hand, and at least two dozen forceps within reach.

I shall perhaps be pardoned for making the following suggestions, which might be of use to those who as yet have had but few opportunities of seeing and dealing with such cases.

Should any difficulty arise during the extraction of the pelvic portion of a cyst, it is advisable to enlarge the abdominal wound at once and to endeavour to make out the exact bearing of the uterus and tumour before proceeding further. If enucleation be determined on, this step is all the more necessary, as want of room serves to increase

tenfold the difficulties of the requisite manipulations.

The capsule should be opened as high as possible on the cyst. I have frequently seen experienced operators in difficulties owing to the retraction of the capsule where enucleation had been begun too low down. Having made a small opening into the capsule with the knife or scissors, the shelling-out should be completed with the fingers, aided by free use of the sponges. The enucleation must on no account be rushed; for if there be any rough manipulation the cyst will be torn, and perhaps a portion of it left behind, and the capsule will be split in one or more places, the very thing least desired. A cyst steadily, gently, and completely shelled out, well repays the operator for the trouble and time spent over the work. To my mind there is no operation in abdominal surgery that requires more patience, judgment, and careful handling than the enucleation of a cyst deeply embedded in the broad ligament.

Cutting with the scissors should be avoided when working in the depths of the broad ligament, for an incautious snip might cause hæmorrhage which would be difficult to control.

In cases where, after enucleation of a large cyst, it is impossible to bring the layers of the broad ligament together owing to intestinal and other adhesions, and where the raw surface of the cavity bleeds freely, packing with iodoform gauze must be

employed. A strip, four inches broad and five or six yards long, should be used for the purpose, one end being allowed to protrude at the lower angle of the abdominal wound. The gauze may be left *in situ* for three days with perfect safety, and when removed it will possibly be quite sweet. This method acts as a drain as well as a hæmostatic force, and is applicable where all other means are unsuitable.

Flushing out the peritoneal cavity is resorted to under the following circumstances. Where the loss of blood has been excessive, and where there is a risk of further hæmorrhage from extensive adhesions; where pus has been met with during the operation, and where foul-smelling cyst contents have escaped into the peritoneal cavity.

As a rule, the contents of ovarian cysts are harmless, and it is by no means certain that the contents of dermoid cysts are poisonous. Colloid or gelatinous material, if left in the abdomen does no harm, and becomes absorbed. No antiseptic solution, however weak, should be used for flushing out. Ordinary boiled water, at a temperature of 105° to 110°, serves every purpose. Some surgeons are particular about removing all the fluid before closing the wound, but this is not necessary; and where there has been much hæmorrhage, it is wiser to allow some of the fluid to remain.

Drainage.—I have never seen any harm result from leaving in a glass drainage-tube for twenty-four

hours, and in doubtful cases it is better to be on the safe side. I never wait now for the clear serum so much talked about, but when the fluid withdrawn amounts to two drachms or so, provided there be no sour smell about it, the drainage-tube is removed. My invariable rule, however, is to turn and elevate the tube at each withdrawal of fluid, thus preventing any blocking by clot or *débris*, and also lessening the chance of inclusion of omentum or intestine. This method was brought to my mind in a case where, at the end of the second day, only a drachm of fluid had been drawn off by the nurse in charge on three consecutive occasions, leading me to believe that the tube should be removed. On raising it, however, some red serum rose in the glass, and with the syringe I drew off five ounces at the time, and several ounces more at the next dressing.

Where drainage has to be prolonged, a piece of stout rubber tubing should be passed down through the glass tube to the bottom of the pelvis, and the glass withdrawn over it, leaving a soft means of drainage which is practically harmless. For cleansing the glass tube I use a one-in-ten solution of sulphurous acid; and here it may be well to mention that the fluid withdrawn immediately after its use is always dark, and not infrequently black.

Closing the Wound.—A little extra care in closing the abdominal wound always repays the operator, whilst the patient is protected by a firm scar. Each layer of the abdominal wall must be taken up

separately from within outwards, or in the reverse manner. It is questionable if it be so absolutely necessary to bring the edges of the peritoneum in apposition. One meets with cases where, owing to adhesion of the cyst to the parietal peritoneum in front, it gets torn so much that it is quite impossible to bring the edges together again. What to my mind is of far more importance is, that the two layers of the sheath of the rectus should be closely united, for on this depends the strength of the wound.

Should the patient be very obese, silk forms the best suture, but in ordinary cases silkworm-gut is preferable. If silk be used, it should be boiled in carbolic solution 1–40 before the operation. Silk-worm-gut must be placed in warm water for an hour before use, otherwise it will break off when tied. Catgut should on no account be employed for the purpose of closing the wound.

All puckering of the skin must be attended to, and superficial sutures of horse-hair or thin silk be put in wherever required.

Dressings.—In ordinary cases simple gauze makes a perfect dressing, but where drainage is being carried out, iodoform or carbolic gauze is perhaps better.

As a rule I use strapping, for should the patient have a cough, or be very fat, the abdominal walls will need support.

Shock is best treated by hypodermic injections of ether or brandy, and by the application of hot-water

bottles to the trunk and extremities. An enema of beef tea with brandy or port wine should be administered, and the patient's head kept low and enveloped in warm flannel.

Sedatives.—When the patient has been placed in bed, fifteen minims each of tinct. opii and belladonna, with three ounces of beef tea, are administered by the rectum. I am inclined to favour the use of opium combined with belladonna after abdominal operations, for to my mind so much depends on absolute quiet for the first twelve hours; and so small are the chances of interfering with the secretion of the kidneys, that I am surprised the practice is not more general. Should it be necessary to repeat the sedative, I have no hesitation in doing so after three hours, and, so far, I have had no occasion to regret it.

Feeding.—My patients are not given anything by mouth for the first twelve hours, unless it be a little hot water to get rid of the taste of the ether, and this must not be swallowed; but should there be no sickness, a little milk with soda- or barley-water may be given at the end of twelve hours. Rectal feeding is usually carried out for the first few days. An enema of beef tea, with a dessert-spoonful of port, if there be much exhaustion, is administered every three hours, and this is quite sufficient as a rule to support the patient for a considerable time. When flatus has passed, a cup of milk, gruel, or beef tea may be given, and on the third or fourth morning,

bread and milk, or beef tea and toast, while by the end of the week fish and light puddings may be partaken of. Whenever there is the slightest inclination towards sickness, feeding by the mouth should be immediately stopped, and enemata or peptonised suppositories substituted. During the days of rectal feeding the rectum should be washed out each alternate morning.

Sickness.—Ether or chloroform sickness is pretty usual, and, unless it be violent and continuous, is beneficial rather than otherwise. Should the vomiting be bilious, sipping hot water with a little bicarbonate of soda in it is very serviceable. When the vomited matter is dark-coloured, a cup of hot strong tea, without milk or sugar, will sometimes act as a charm. Sickness due to flatus is met with any time after the first twelve hours, and must not be mistaken for one of the symptoms of peritonitis. Twenty-drop doses of sal volatile and chloric ether often give immediate relief. The vomiting which accompanies septicæmia, and precedes death, is, so far as I know, uncontrollable. Washing out the stomach and repeated doses of white mixture might be tried, but I fear with little chance of success; such a condition is hopeless.

Secondary Hæmorrhage is usually due to the slipping of a ligature on the pedicle, omentum, or some large adhesion. If the case is being drained, of course the mischief is quickly detected, because the blood will appear in the tube and on the sponges;

but where drainage has not been employed, the situation is very different. It is therefore of the utmost importance that the symptoms of internal hæmorrhage should be recognised early, otherwise the patient will bleed to death.

Secondary hæmorrhage may occur at any time within thirty-six hours after the operation, and during that time the patient must be carefully watched. When a patient who has been going on satisfactorily, suddenly feels faint, grows pale, and becomes restless, and has a rapid and small pulse, with coldness of the nose, ears, and extremities, there is hæmorrhage almost to a certainty, and the first and only thing to be done is to reopen the wound, place a fresh ligature, and wash out the abdominal cavity.

Flatus.—Quinine in fifteen-grain doses, given by the rectum, rarely fails to bring the flatus down. Raising the foot of the bed on blocks is a plan worth trying, as it gives the intestines a chance of moving. Should the flatus not pass down, the temperature almost always rises and the pulse quickens, but after its escape both temperature and pulse resume their normal course.

In cases of abdominal distension I am of opinion that opium and belladonna should be given in order that the intestines may have time to recover from what I take to be temporary paralysis due to an excessive quantity of flatus.

If the passage of flatus be delayed beyond seventy-

two hours, I resort to full doses of quinine, which generally have the desired effect.

Temperature.—In my earlier cases temperatures of 104° and 106°, were not rarely met with; and I have no doubt that such extreme rises, occurring as they did within forty-eight hours after the operations, were due to the absorption of carbolic acid from the spray. At any rate, with the disuse of the spray, such rises of temperature have been almost unknown. To subdue hyperpyrexia I usually give twenty grains of quinine by the rectum, and should the temperature still remain high, the dose is repeated in three hours. Antipyrin in twenty-grain doses, together with ten grains of quinine, is a good combination, the latter drug seeming to lessen the depression caused by the former. Leiter's tubes are very useful and do not involve anything like the amount of trouble caused by the employment of the rubber ice-cap.

Pulse.—Too much importance is, I think, attached to rapidity of the pulse. I have frequently noticed pulses of 120, small and irregular, in neurotic patients, and this is most observable about the second day, at the time when the flatus is most troublesome; yet these patients have no other symptoms that give rise to anxiety. In the absence of further indications, a rapid pulse should not be looked upon as denoting danger.

Sepsis in the form of septic peritonitis may be looked for about the second or third day. The patient's temperature rises, the pulse is rapid and

bounding, there is abdominal pain with tenderness and distension. The face assumes an indescribable look, which, when once seen, is never forgotten ; the tongue becomes dry and brown, vomiting sets in and soon becomes uncontrollable; there may or may not be diarrhœa, and towards the end delirium. The only treatment which has given me any satisfaction is quinine in twenty- to thirty-grain doses, which may be repeated in four hours, and free administration of alcoholic stimulants by mouth or by rectum.

Bowels.—On the fifth or sixth day the bowels are opened by an enema of four ounces of olive oil, followed in an hour by two pints of soap and water. To keep the bowels in order, a two-and-a-half-grain col. hyoscyamus pill is given every second night if necessary.

Cystitis.—This condition is due in most cases to bad nursing and want of cleanliness. Almost every instance can be traced to the catheter, and to the method of its introduction. The chief point to be remembered is, that the orifice of the urethra should be cleansed with some antiseptic solution previous to introducing the catheter. Now that we have glass catheters, such cases should be seldom met with.

Cystitis is usually amenable to treatment, if properly attended to. The bladder should be washed out at least twice daily, by means of the siphon, with a weak solution of boric acid. Milk diet and demulcent drinks are called for. Lithia, and soda water, and tea, may be freely partaken of, and a mixture

containing hyoscyamus and uvæ ursi given thrice daily. Later on muriatic acid and buchu will be useful.

Parotitis.—So far, I have not had any such condition among my patients, but I have seen cases in the practice of others.

Insanity.—Two of my patients became insane, and in both instances the mental condition took the form of acute mania. Both women recovered, and have had no recurrence.

SHORT HISTORY OF CASES AND OPERATIONS

1

Mrs. M., a short, thin, sharp-featured woman, aged sixty-one, widow, married at twenty-nine, has had six children, the youngest being twenty-one years of age. First child stillborn, all the other labours natural. Menses appeared at fifteen, ceased at forty. Has never been very strong. Her mother died of "cancer of the liver." About twelve months ago she noticed herself getting large, and thought she was gaining flesh. Later on, owing to gradual increase in her size, the swelling being uniform and painless, she believed she had "the water." Within the last six months she lost flesh rapidly and complained of difficulty in passing water, and of pressure on the bladder, together with forcing down pains, and these symptoms led her to seek advice. On examination, I found the abdomen much distended, with dulness over the anterior surface, and resonance in the flanks. Fluctuation could be distinctly made out. Per vaginam, the uterus was found to be retroflexed and low down in the vagina, and the base of the tumour could be felt on the right side.

The operation was performed on September 13, 1882. Chloroform being administered, I was about to commence, when the patient vomited several times, and in a few moments became pulseless. Some time elapsed before she was brought round. As it seemed dangerous to go on with the chloroform, ether was proposed, and administered without the slightest inconvenience, both pulse and respiration at once improving under its influence, and the vomiting ceasing. The tumour was removed without much difficulty. The left ovary was only enlarged to the size of a walnut and I left it alone. There was very little bleeding, and no fluid escaped into the peritoneal cavity. The wound was closed with carbolised silk sutures. The tumour contained about twenty pints of a brownish-coloured fluid and colloid matter. The sutures were removed on the eighth day.

From the first the patient suffered from cystitis, the urine at times being loaded with pus. I treated this condition by washing out the bladder occasionally with warm water, and gave twenty-minim doses of tincture of perchloride of iron three times a day.

2

M. W., a tall, dark-haired, rather stout woman, aged thirty-three, married fifteen years, has had eight children (one premature at the end of the seventh month) and two abortions. The catamenia appeared at the age of thirteen, and up to the year

1877 she has always had good health. There is no history of tumour in her family. She stated that five years ago, when about seven months gone with her seventh child, she was coming out of Victoria Station, and slipped on some orange-peel, and fell, striking the left side of her abdomen against the kerb. She was stunned for a few moments, but recovered, and afterwards went her full time, and had a fairly good labour. Some days after her confinement, however, she had an attack of what her medical attendant termed "inflammation of the womb," which laid her up for three weeks. Two months subsequently she had rheumatic fever, and kept her bed for seven weeks. About a year after the fall, when three months advanced in her eighth pregnancy, she noticed on her left side a perfectly movable swelling the size of an orange, and complained of a dragging pain in that side. She aborted at the fifth month, and was attended by a midwife, the abortion being followed by another severe attack of "inflammation." Two-and-a-half years ago she completed her ninth pregnancy, and had a lingering labour. After her delivery her medical attendant found a large swelling in the left side, and diagnosed "an abdominal tumour of doubtful nature." She was told to go to some hospital for further advice, and attended for seventeen months as an out-patient at different London hospitals, but the abdominal condition seems to have been overlooked. In April 1882, when three months gone in her tenth pregnancy,

the pain in her left side became so bad that she fainted on several occasions, and at last took to her bed. During the next four months her sufferings increased to such an extent that she could not lie down in any position, but had to be propped up in bed, or in a chair, in order to procure sleep. She was prematurely confined of a living child at the middle of the seventh month, after a painful and tedious labour extending over two days. Her confinement was followed by increased pain in the left side, which continued to within a week of the operation. She told me—and her statement was confirmed by her medical attendant—that in her last two pregnancies the child lay in the right side, but more particularly so in the last, when the womb was pushed completely to the right of the navel, and after delivery a distinct hollow could be felt and seen on the right side, whilst the swelling in the left remained almost unaltered. After her last confinement the tumour began to grow rapidly, and she lost much flesh. Her appetite failed, and her spirits became depressed. Menorrhagia and metrorrhagia were frequent symptoms, and she complained of pressure over the bladder, with difficulty in micturition. The constant pain and loss of sleep had reduced her to such an extent that walking was out of the question, and the slightest exertion produced giddiness and faintness.

I first saw her in January 1883. She was then pale and much emaciated, her features were drawn

and pinched, and she seemed too feeble to stand. She complained of a constant dragging and tearing pain in her left side, which prevented her lying down, and kept her awake at night. Further examination showed her abdomen to be irregularly enlarged and very tender. There was dulness over the front, and resonance in the flanks. Fluctuation could be detected in parts, and aortic impulse was perceptible. The tumour was movable and seemed pretty solid. On vaginal examination, the uterus was found to be enlarged and anteverted, the os was patulous, and the sound passed two inches and a half. The diagnosis was: "A multilocular tumour of the left ovary with little fluid." The patient being in such a wretched state of health, I determined to wait till after her next period, and put her on a course of iron, and gave her carbonate of lithia in five-grain doses three times a day, to correct the urine, which was thick and loaded with urates. She rapidly improved under this treatment, but the tumour gained in size. Accordingly, on February 6, 1883, I performed ovariotomy.

The patient being chloroformed, I opened the abdomen under carbolic spray, and found the tumour free from adhesions on the right side, but on the left there were several long thin bands stretching from the abdominal wall, and in front a portion of the intestine had become attached to the tumour by a thin band, which required ligaturing. The contents of the tumour being too thick to pass through the

trocar, it was withdrawn, and introducing my hand I broke down several secondary cysts, but in the end had to enlarge the incision before the mass could be extracted. The right ovary, being enlarged and cystic, was also removed, and the peritoneal cavity well sponged out. The wound was closed with carbolised silk sutures, and dressed with antiseptic gauze. The tumour weighed over twelve pounds.

The patient made a good recovery. On the third day she passed her water voluntarily, and both pulse and temperature were normal. On the seventh day the sutures were removed, when the wound was found to be quite closed. On the eleventh day the bowels acted, and before the end of the third week she was up and able to walk. She is now in good health and has resumed her duties at home.

This case seems to me interesting, because it shows that during the development of an ovarian tumour several pregnancies may occur, and end in the birth of living children, and in the safety of the mother.

3

In January 1884, I removed a small ovarian tumour from a patient aged twenty-eight, single. The operation was a simple one, and the wound healed rapidly, all the sutures being removed by the seventh day, and the pulse and temperature being both normal by that date. Late on the following night, I received an urgent message, saying "that

my patient had been taken with vomiting, and was complaining of pain in the back, headache, and sore throat. The temperature had gone up to 101°, and the pulse to 120°, and a red rash had come out over her face and chest."

When I arrived at the house, I found the patient in a state of great excitement, owing to the nurse in her fright having said something about scarlatina. Her face was flushed, and her neck, shoulders, and body were covered with a bright red rash. She complained of swelling and soreness in her throat, and of burning and itching of the skin. Her temperature was over 102°, and the pulse 130. The bowels had acted well, and there was no scantiness of urine. She had not eaten fish or meat, but was still on a light diet. In fact, there was nothing to account for the attack, except that she had on that day heard of the sudden illness of her mother, an old lady of sixty-five years. The vomiting, pains in the back, sore throat, headache, high temperature, and quick pulse rather alarmed me at first, but the suddenness of the attack and breaking out of the rash, together with the burning and itching of the skin, and the state of the tongue, led me at once to diagnose urticaria diffusa.

I gave her a dose of white mixture and ordered 20 grains of soda bicarb. every two hours, and a lotion of the same ʒj ad ℥j to allay the itching. I attempted to reassure her, but she was so nervous and excited about her condition, refusing to believe

it was other than scarlatina, that I had to give her a full hypodermic injection of morphine in order to quiet her. By the next morning the rash had left the body, but was still visible on the limbs, and within twenty-four hours it had quite disappeared, and the pulse and temperature had become normal. The rash was not followed by desquamation.

I take it that this form of urticaria, attended with a diffuse rash instead of the usual distinct wheals, is uncommon, and might, with such symptoms as were met with in this case, be easily mistaken for scarlatina at first sight. So far as I could judge, this attack was not brought on by any error of diet, and I should be inclined to attribute it to some disturbance of the nervous system.

Two years afterwards this patient met with an accident on board a steamer. She slipped down the cabin stairs and strained herself. Almost immediately she was seized with abdominal pains and vomiting, and died in a few days, the cause of death being peritonitis following strangulation of the intestine.

4

S. W., aged twenty-five, single, was first seen by me in consultation with Drs. Jeaffreson and Carter in September 1885. The following history was elicited. Menstruation appeared at the age of fifteen, and had been irregular and scanty; latterly it occurred every fourteen days. In the preceding May

she was seized with abdominal pains, and then for the first time noticed a swelling in the lower part of her abdomen. Since then the tumour had gradually increased until it impeded her breathing, and compelled her to give up her work and take to her bed. Thirteen days previous to her visit to me she had been seen in consultation by a specialist, who, in order to relieve the immediate symptoms, had tapped the tumour and drawn off eight pints of fluid. Examination showed the abdomen to be swollen, tender, and tympanitic, the lower part being œdematous, red, and pitting on pressure. There was dulness in both iliac regions, and resonance in either flank, when the patient was turned on the opposite side. The uterus was in front of the tumour, with the fundus pushed well forward. Fluctuation could be detected on the right side of the abdomen, and in the pelvis. The tumour was fixed and there was great tenderness. The colons were distended. The opening where the patient had been tapped was patent and red, and a fœtid, sanious discharge issued from it. Urine was passed frequently in small quantities, but there was no albumen in it. The tongue was dry, brown, and furred, and there were sordes on the lips; respirations 30, short and laboured; no cough; heart sounds normal; pulse 132, running and small; temperature 102°.

The condition diagnosed was: "A tapped ovarian multilocular cyst, with purulent contents escaped into the peritoneal cavity. Septicæmia."

On the 5th of September, chloroform was administered, and I opened the patient's abdomen, the incision being four inches in length, increased eventually to six inches. The peritoneum was thickened and the tumour was adherent to the abdominal wall, the adhesions being recent. The cyst was quite rotten and friable, full of stinking fluid, pus, and flaky lymph, a large quantity of which had also escaped into the abdominal cavity; it was universally adherent, the pelvic adhesions being old and tough. The intestines were red and injected. I introduced my hand and emptied several cysts before extracting the tumour. There was a long, thin pedicle, which was easily secured. The peritoneal cavity was then well washed out with boiled water 105°, and cleansed as much as possible, and all the bleeding points tied with thin silk ligatures, and a drainage-tube inserted. Very sharp hæmorrhage had occurred from the adhesions, especially the pelvic ones. The tumour weighed in all twenty pounds, six pounds solid, and fourteen pints fluid.

The patient was quite collapsed, and only lived seven hours after the operation. I imagine that with my present experience this poor woman might have been saved.

5

E. C., a thin, tall woman, aged sixty-one, married, three children, the youngest being twenty-eight years of age, came under my notice in March 1886.

For some weeks she had been increasing in size, and was troubled with frequent micturition. At the same time there was marked emaciation about the chest and upper limbs.

Her abdomen was enlarged, particularly on the left side, where percussion gave a dull note. No fluctuation could be detected in the tumour, which filled the left side of the pelvis, and was closely connected with the uterus, that organ being pushed to the right side, somewhat in front of the swelling, its body being easily felt on the right side through the abdominal wall. On opening the abdomen a pink-coloured tumour was exposed to view, confirming the diagnosis of broad ligament tumour. The cyst was enucleated, and both layers of the broad ligament were stitched together. The left side of the uterus bled so freely that it was necessary to topsew the uterine cornu before it could be controlled. The abdominal wound was then closed. Flatus passed in twenty-four hours, and the highest temperature recorded was 102°.

The patient was in good health when last seen in 1892.

6

E. W., a medium sized, rather stout woman, with bright colour, aged forty, widow, has had two children and one abortion, the youngest child being ten years of age. She came to me for advice in April 1886, and complained of abdominal pain and tenderness,

from which she had suffered for some time past, and there had also been some loss of flesh. Menstruation had been regular, but painful, and of late she had been troubled with floodings.

Examination disclosed a fixed tender swelling on either side of the uterus, that organ being large and pushed forward.

The operation was comparatively simple, the adhesions being recent. There was no flushing or drainage employed.

Flatus passed forty-eight hours after the operation, and the temperature never went above 100°. The convalescence was uninterrupted. The patient was alive and well in 1894.

7

Acute Mania following Rupture of the Rectum by Enema thirteen days after Ovariotomy. Recovery.

M. W., aged forty-three, was sent to me in September 1886, suffering from a large abdominal swelling. She gave the following history. Married twenty years, but had never become pregnant. Health good up to two years ago, when she first noticed a swelling in her left side, and had difficulty in passing water. She also complained of backache and pain in the lower part of the abdomen, and was troubled with an offensive brown-coloured discharge from the vagina. Menstruation became irregular

and painful, the flow varying in quantity. The swelling increased rapidly, extending from left to right, and filling up the whole "abdomen." Some weeks before her visit to me, she had an attack of inflammation in the abdomen, which seemed to fix the swelling, and greatly impeded her breathing. When I first saw her it was evident that she was suffering greatly and in a dangerous condition. Her face was drawn, lips blue, nostrils dilated, conjunctivæ suffused, and the respirations forty to the minute; pulse 120; temperature 100°; skin dry, tongue foul; bowels costive, and the urine scanty, high-coloured, and loaded with lithates, sp. gr. 1028, no albumen or sugar. The abdomen was greatly distended, the circumference at the umbilicus measuring fifty inches. There was dulness over the whole surface, except far back in the right flank, and immediately below the ensiform cartilage. No distinct fluctuation could be made out.

Bi-manual examination revealed the uterus in front of the tumour, drawn high up on the right side, the body and fundus being easily distinguished through the abdominal wall. Per vaginam, the cervix uteri could be felt behind the pubis, and the sound passed into the uterine cavity to the extent of three inches with a forward curve. The lower part of the tumour was firmly wedged in the pelvis, and pulsation could be detected through the vaginal wall.

On September 16, 1886, ether was administered,

and the abdomen opened. The tumour was found to be universally adherent to the parietal peritoneum, omentum, and intestine, and much time was spent in separating adhesions and securing bleeding points. The pelvic portion of the tumour was enucleated, and the capsule fastened to the lower end of the abdominal incision. The peritoneal cavity was then thoroughly sponged out, and a drainage-tube placed in the sac formed by the capsule. The wound was closed with silk sutures and dressed with carbolic gauze, and the patient was then removed to bed after an operation lasting three-and-a-half hours. Much blood had been lost, and the patient was extremely collapsed, but she rallied well and had no sickness. The tumour removed was a cystic papilloma of the left ovary, burrowing deep into the left broad ligament. The contents were dark and gelatinous, and the cyst-wall was in parts half an inch thick, with masses of papilloma spread over it.

The first urine drawn off was dark with carbolic acid, and this condition lasted for three days, after which the urine was quite clear. Flatus did not pass voluntarily till forty-eight hours after the operation. A metrostaxis occurred on the third day and continued for a week, during which time the pulse averaged 120, and the temperature ranged between 104·6° and 101·8°.

At the end of the first week the abdominal wound had healed, but the drainage-tube was

left *in situ* as a couple of drachms of sour, sanious fluid were drawn off through it night and morning.

On September 24th, the eighth day after the operation, an enema of ten ounces of olive oil was ordered. By an unfortunate mistake, a pint and a half of soap and water was given after the oil, and there being no immediate action of the bowel, this was followed by another injection of soap and water, the result being that the rectum burst, and the fluid came through the drainage-tube, saturating the dressings. The patient afterwards declared "that whilst the enema was being administered, she felt a sudden pain, as though something had given way in her inside, and almost immediately the bandages became soaked through." About four hours after the accident, I was informed of the occurrence, and on examining the patient, found fluid still welling out of the drainage-tube. As much fæculent fluid as could be got out of the tube was drawn off by the syringe, and an enema-tube passed into the rectum, to assist in draining the intestine. A large pad of absorbent iodoform dressing was placed over the abdominal wound, and the patient put into another bed. Pulse 120; temperature 101·6°. Within the next forty-eight hours the temperature rose to 102·2°, but there was no pain or abdominal distension, and the only trouble complained of was "a soreness of the back passage." Fæcal matter and flatus were constantly passing through the drainage-

tube, but no bad symptoms appeared, and the patient went on as if nothing had happened.

On September 27th, the eleventh day after the operation, and the third following the accident with the enema, the patient appeared restless, and had little or no sleep. The temperature was 101·2°, and the pulse 130. Later on in the day the temperature rose to 102°, when she began to talk nonsense, and at night became delirious. As it was difficult to keep her quiet, the drainage-tube was removed and twenty grains each of chloral and bromide of potassium given by mouth, and ordered to be repeated every four hours if necessary.

September 28th.—An ounce of castor oil was given by the mouth, after which the bowels acted freely and without pain; but some fæcal matter came through the tube-opening in the abdominal wall. Evening temperature 101·8°; pulse 120. The patient had had no sleep for twenty-four hours, and lay tossing about in bed and talking wildly.

September 29th.—On the thirteenth day after the operation, and the fifth following the accident, the patient became maniacal, and made several attempts to get out of bed. Half a drachm of tincture of opium was ordered to be given every third hour, but after the second dose she became so excited that I ordered the drug to be discontinued, and the chloral and bromide mixture, with the addition of half a drachm of tincture of hyoscyamus, to be resumed. She derived no benefit apparently from the change

of medicine, for she got no sleep, and was extremely violent throughout the night. Evening temperature 101·8°; pulse 122.

September 30th. — Patient worse, very restless. Morning temperature 101°; evening temperature 100·8°; pulse 140. She complained of pain in the "stomach," for which a drachm of tincture of hyoscyamus and twenty grains of chloral were given.

October 1st.—The afternoon temperature rose to 102·8°; pulse 130, and thready. Twenty grains of quinine were given by mouth, and an ice-cap put on. A tablespoonful of champagne was directed to be given every hour till further orders. The temperature fell to 100·2°, within an hour and a half, and the patient had some sleep; pulse 110, and stronger.

October 2nd.—She seemed to be slightly better, so the stimulant was decreased, and more fluid food administered by mouth. Temperature lower and pulse stronger.

October 3rd, 4th, 5th.—During these three days she appeared to get worse. Fæces and urine were passed involuntarily, and she became unmanageable. A sixth of a grain of morphia was injected hypodermically, but apparently it increased the excitement, and therefore was not repeated, ʒj doses of tincture of hyoscyamus being substituted.

October 6th. — Patient had a rigor. Afternoon temperature rose to 103°; pulse 140. Twenty grains of quinine were given by rectum, and the tempera-

ture fell to 100°, in about two hours. Fæcal matter still issued from the abdominal wound. She was extremely violent.

October 7th.—The morning temperature suddenly dropped to normal, but the pulse kept about 120. She was very excited and savage, requiring constant watching.

October 8th.—Much exhausted. A mixture of ammonia and bark was given every three hours, and a tablespoonful of brandy every hour. She slept a little during the night, and was much quieter the whole of the day. Afternoon temperature 100·2°; pulse 120. Skin dry, tongue moist, and urine normal.

October 9th.—Temperature this morning 98·2°. A large slough containing deep ligatures was extracted through the wound. Patient much stronger, but mental symptoms worse. She refused to take her food, and tried to bite her attendants whilst being fed. Pulse 120; evening temperature 100·6°. One-fourth of a grain of morphia injected, but without much benefit. Stimulants, egg-and-brandy mixture every hour in half-ounce doses.

October 10th.—Mental condition much the same. Morning temperature 100·6°; in the afternoon 98·6°.

October 11th.—Another large slough containing deep ligatures came away. For the first time since her attack patient had several hours' sleep. Morning temperature 99·6°; pulse 120. It was noticed that she was passing large quantities of limpid

urine, alkaline, sp. gr. 1005, and containing a trace of albumen. Evening temperature fell to 98·6°.

October 13th.—Large slough with ligatures extracted. Temperature varying between 99° and 100·6°; pulse 130, and small.

October 14th.—Another slough containing ligatures came away. Evening temperature up to 101·4°. Patient very violent and wakeful.

October 15th.—Rectum cleared by enema, part of which escaped through the tube-opening. Large quantities of limpid urine drawn off by catheter. Morning temperature 99°; evening 101·6°.

October 17th.—Morning temperature 98·6°, but at midday it rose to 102·6°, and the pulse to 120. She became wildly maniacal, and restraint had to be employed. Twenty grains of quinine were administered by rectum, and ten grains more three hours afterwards. In less than an hour after the second dose the temperature had fallen to 100°, and the pulse to 105. Sixty ounces of urine were drawn off in twelve hours. During the next five days there was not much change in the patient's condition. Her temperature remained below 101°, and pulse between 105 and 110. She refused her food, and had to be artificially fed. Slept from time to time, but when awake was beyond control.

October 23rd.—Patient had an attack of diarrhœa and complained of pains in the abdomen. The morning temperature fell to 97·4°, and the pulse was extremely feeble. The extremities were cold and

clammy, and she seemed to be in a state of collapse. Chalk and opium mixture was given to check the diarrhœa, and hot brandy-and-water administered by the mouth. Hot-water bottles were placed to her sides and feet, and a mustard-leaf applied to the cardiac region.

October 24th.—Patient had a good night and slept well. She awoke refreshed, and her mental condition showed marked improvement. She seemed to know when she was passing urine or fæces, and called for the bed-slipper. The quantity of urine drawn off in the last twenty-four hours amounted to sixty ounces. Highest temperature 101°.

October 25th.—Two ligatures removed from capsule. Patient slept for four hours and seemed better in every way.

October 26th.—A small piece of mutton chop was given for dinner, and she seemed to relish it. Slept for five hours afterwards and awoke refreshed.

October 27th.—The restlessness reappeared, and later in the day she again became decidedly maniacal. Pulse 130, and bounding; afternoon temperature 101°. She seemed to have great abdominal pain, therefore half an ounce of castor oil was given by the mouth, and an enema administered afterwards, but without much result. Evening temperature 100°.

October 28th.—The afternoon temperature rose to 103·2° but no rigor was noticed. Another large slough containing deep ligatures was extracted

through the abdominal wound. Twenty grains of quinine were given by rectum, and the temperature fell to 100·8°, within two hours, and the pulse was reduced from 120 to 100 beats. The bowels were cleared out by castor oil, given by the mouth, and the patient quieted down, and had some refreshing sleep, and awoke in a much better condition.

She improved mentally and bodily during the next three days, but the temperature kept about 101°, and the pulse varied between 120 and 100.

November 1st.—Temperature in the morning 98°, in the afternoon 101·6°. The bowels acted four times, and by night the temperature had fallen to 100·4°.

November 3rd.—The patient appeared much better, but seemed rather dazed and unable to collect her thoughts. However, she recognised her attendants, and was quieter than usual. Midday temperature 98·2°, pulse 110°; evening temperature 101°.

For the next two days she continued to show marked improvement, her appetite increased, she slept well, and behaved in a reasonable manner.

November 6th.—Her temperature rose in the afternoon from 99·0°, to 103°, and the pulse increased to 130. An ounce of castor oil was given by mouth, and the lower bowel cleared out by enema. Twenty grains of quinine were also given by mouth with good result, the temperature falling in a few hours to 100·2°, and the pulse being reduced to 112.

November 7th.—For the first time since the attack she talked sensibly, and even asked questions. She declared "that, during her illness, her impression was that she had been confined of twins, and that they had been taken away and kept from her without her consent." She also maintained "that if restraint had not been used, she would have injured her attendants." Highest temperature 100·8°; pulse 120.

During the next week she rapidly gained strength, and sat up in bed to meals, and fed herself. With the exception of slight outbursts of temper, she appeared to be quite rational.

November 14th.—Menstruation came on without discomfort. She had complete control over her rectum and bladder. The abdominal wound was much smaller, but flatus and fæcal matter still passed through it. Pulse 100°; evening temperature 100°.

November 27th.—Patient able to walk about her room and remain up for hours. She is now perfectly sane and quiet, her only trouble being the fæcal fistula, which is, however, rapidly closing.

A few days later she returned home quite convalescent.

Remarks.—I venture to report this case not alone because of the attack of mania following ovariotomy, but also to record the unfortunate accident with the enema. Rupture of intestine by enema is fortunately of rare occurrence, but the fact of such an accident

having happened, serves to show that rectal injections cannot be too carefully given at all times, and especially in diseased conditions of the intestine, or where drainage is being carried out in abdominal cases. In this particular instance the probability is that, during the enucleation of the tumour from between the layers of the broad ligament, the rectum had been exposed, and that the glass drainage-tube had rested on the intestine, which gave way under pressure of the copious enema, injudiciously administered. There is little to be said about the treatment adopted throughout this case. Morphia and opium failed to quiet the patient, and indeed seemed to increase the excitement. Chloral and bromide of potassium appeared to do some good, but the doses had to be increased from time to time, as the drugs seemed to lose their effect after a few days' use. Tincture of hyoscyamus was tried alone and in combination with the chloral and bromide mixture, and certainly soothed the patient when all else failed. Quinine in 20-grain doses, given by mouth or rectum, seldom failed to lower the temperature within two hours, and was invaluable in subduing the hyperpyrexia.

The question of stimulants is a vexed one; but in my opinion, much good was done in this case by the discreet administration of alcohol. When the patient was at her worst, I gave large quantities, with undoubted benefit, and I feel certain that she owes her recovery in a great measure to this treatment, for

the discharge from the abdominal wound was profuse, the emaciation rapid, and the exhaustion extreme.

The first symptoms of mental disturbance appeared on the eleventh day after the removal of the tumour, and the third following the rupture of the intestine. Two days later the patient became maniacal, and remained so for seven weeks, after which time she recovered her reason, and made a rapid convalescence. This was undoubtedly a case of acute mania, but the question may be asked, To what was the attack due? The fact that insanity has frequently followed operations on the ovaries and uterus is abundantly proved. Keith, Tait, Bantock, Thornton, Meredith, Barwell, Cullingworth, and Dent have each met with one or more cases. Some of these recovered, others remained incurable, and a few died raving mad. In some of these instances the patients had shown decided symptoms of insanity before operation, and with these the subsequent attack was simply a recurrence; but with the others it was different, for up to the date of operation they had been perfectly sane, and no history of insanity could be discovered in their families. In the case here recorded, beyond the fact that the patient's brother died from "abscess in the brain," there was no history of cerebral mischief. Her husband, however, assured me that for some time previous to the operation she had been in a very depressed state, and frequently said "she would go mad and die in an asylum." This state-

ment would seem to indicate that anticipation or anxiety, prior to the operation, may have had some influence in bringing on the attack. As exciting causes, shock after the operation, or alarm at the accident must not be overlooked.

It has been said that insanity may follow the administration of some anæsthetics, but I must confess that I have never seen a case of this kind, nor do I know of any instance where insanity has been induced in a patient who beforehand was perfectly sane, and in whose family history there was no evidence of madness. In the case under consideration the anæsthetic employed was ether.

The condition of the urine may have had something to do with the attack, but it must be remembered that the carboluria had passed off many days before the symptoms of insanity appeared, and, moreover, at no time was there a scarcity of urine, and only a trace of albumen was detected occasionally during the period of polyuria.

Mental disturbance due to absorption of iodoform is, I imagine, not of rare occurrence. I have seen three such cases where there was delirium, high temperature, and complete prostration. All the patients were in extreme danger, but recovered on the removal of the exciting cause. At the same time, the mental symptoms never went beyond slight delirium. Mr. Barwell, in a paper read before the Medical Society, has pointed out "that disturbance of the generative organs might possibly be a cause

of insanity following such operations as ovariotomy and hysterectomy."

Mr. Dent, however, in a very able contribution to the "Journal of Mental Science" has clearly proved that insanity may follow herniotomy, amputations, dentistry, and has been frequently noticed after accidents. Mayo Robson has also mentioned a case of acute mania following the passage of a gall-stone. Hence it would seem that any operation may bring about an attack of mania, or some form of insanity.

I am inclined to agree with Mr. Dent that many of the cases of insanity following abdominal operations, especially those cases where the symptoms have not immediately shown themselves, but appeared a week or two afterwards, are of septic origin, and are similar to those cases of puerperal insanity which are not infrequently met with in practice. In the case just narrated, the septic condition of the patient, increased probably by absorption of fæcal matter and gases, subsequent to the rupture of the intestine, would seem to have been a potent factor in bringing about the maniacal attack, for the accident was soon followed by mental symptoms which culminated in acute mania.

Mrs. W. called on me in April 1895. She is now a big, stout woman in the best of health and spirits.

The fæcal fistula has quite closed, but there is a ventral hernia, which, however, does not cause her the slightest inconvenience. There has been no

return of the mania, the mind is perfectly clear, and she shows no trace of any former mental trouble.

May 1896. The patient is in good health.

8

A. A., a tall, dark woman, with pale face, aged fifty, married, three children, the youngest child being twenty-five years of age, came to me for advice in November 1886. Her menstrual history had been quite natural. Ten years ago she suffered from congestion of the lungs and pleurisy. Five years later she was ill with typhus fever, and two years subsequently had a flooding. About one year before her visit to me she first noticed a swelling in her abdomen, which had rapidly enlarged within the last six months, while at the same time she became very emaciated. This enlargement, and the "forcing of her water" were her chief troubles, but she also complained of sharp pain in her back, and in the right side.

Examination showed the abdomen to be immensely distended, the lower ribs being pushed out by the tumour. There was dulness all over the abdomen, and in both flanks. Bimanually, fluctuation could be easily detected. The tumour was, if anything, more to the left side, and was in front of, and to the left of, the uterus, that organ being enlarged and pushed down; the cervix being split and erosed. The sound passed three inches. On the vaginal

wall were two flat nodules, somewhat like sarcomatous growths.

The operation was severe. The abdominal walls were thin and much stretched. The tumour was universally adherent. On tapping it, the contents were found to be glairy and too thick to pass through the trocar; the hand was therefore introduced, several locules broken down, the contents scooped out, and the tumour then extracted. The pedicle was broad and thin, and the ligature cut through it easily, necessitating the application of a second ligature. The pelvis was full of papillomatous growths, which bled freely, and rendered the pelvic adhesions very difficult to deal with. The abdominal cavity was washed out and drained.

The patient was sick all through the operation, and when put to bed, vomited freely, at first yellow, then green, acid-smelling fluid. This condition lasted for three days, and then the vomited matter became black. The patient was so exhausted that she lay with her head on one side, and simply "lobbed" out mouthfuls of grumous fluid. Every possible remedy was tried, and the stomach was freely washed out, but still the vomiting continued. At last, at the end of the sixth day, the patient, at her own request, was given a cup of strong tea, without milk or sugar, with the result that she kept it down, and never vomited afterwards.

She recovered and was sent home well, but died

three years later of papillomatous disease of the abdomen and pelvis.

9 and 12

J. R., aged thirty-four, single, a tall, thin, dark-haired, sallow-complexioned woman, was sent to me for treatment in January 1887, on account of a gradually increasing difficulty in passing water. She complained that the urine was constantly dribbling away, and that though she experienced pain in her bladder, and a desire to micturate, yet she could not pass water in any quantity unless she lay on her face, or on her right side. On examining the patient's abdomen, a central swelling was noticeable. It extended to the umbilicus, was movable from side to side, fluctuated freely, and was dull on percussion. Pressure on the swelling caused uneasiness, but there was no actual tenderness.

It being obviously a case of distended bladder, a catheter was passed, and over two pints of urine were drawn off, to the immense relief of the patient. The bladder was then explored, but no stone or growth could be detected. On proceeding to further examine the pelvis bimanually, I discovered an elongated hard tumour lying in front of the uterus, and pressing on the bladder. The tumour was easily dislodged from its position, and, when pushed aside, fell back into the right iliac fossæ. The uterus was

enlarged, its cavity measuring three inches, and the patient declared that she lost freely at each period. Otherwise she was in fair condition of health, and was unaware of the existence of any abdominal tumour up to the time of her examination.

It was evident that the tumour was the cause of the patient's symptoms. I therefore opened her abdomen a few days later, and removed a kidney-shaped dermoid tumour of the right ovary, which contained hair, bone, and two teeth. The operation was simple, and the patient made an uninterrupted recovery, being able to go home at the end of the month completely cured of her bladder troubles.

At the time of the operation, the uterus was noticed to be enlarged, but there did not seem to be any indication sufficient to justify the removal of the other ovary. Within a year, however, the patient returned, complaining of a small lump in her abdomen, which was so tender that she could not fasten her clothes at the waist, owing to the agony produced by the pressure. The lump, she said, increased in size, and became exquisitely painful about the time of her monthly periods, and these lasted a fortnight or three weeks, so that she was hardly ever clear. The uterus now reached to the umbilicus, its cavity measuring four inches. The lump, which was evidently the left ovary, drawn up and twisted forward by the uterine growth, could be felt in the middle line, about three inches above the pubis. Pressure on it caused excessive pain and

faintness. It was decided to remove the ovary, and, the patient consenting, the operation was performed without any special difficulty. Her convalescence was uninterrupted. A metrostaxis set in a week after the operation and lasted about two days. From that date the patient has never menstruated. Seven months after the second operation, I examined her pelvis and found the uterus much reduced in size, the probe passing three inches and a quarter. In February 1890, the patient's uterus was normal, and no trace of the uterine growth could be detected. She is now in excellent health.

10

E. S., a tall, dark, nervous woman, aged forty-two, single, came to me in July 1886. The following history was given. Menstruation irregular and scanty, but painless. About two years ago she was laid up with rheumatic fever. For the last eight months or more she had been ill, the illness beginning with pain and swelling in the left side, in the lower part of the abdomen, and in the rectum, and during the last few months the pain had increased, both before, and at the period. About two years back a lump was noticed in her left side, which was now increasing very rapidly and was exquisitely tender, the slightest pressure on it producing sickness. There was much emaciation, and she suffered from recurring attacks of pain and vomiting.

On examination, the tumour was seen to be closely connected with the uterus, and was in front of, and to the left side of, that organ. There was distinct fluctuation, and dulness over the swelling, but resonance around it and in the flanks, more especially in the right iliac and lumbar regions. The swelling, which was rather to the left side of the umbilicus, was not very movable.

The operation was tedious, the tumour being enucleated with difficulty, owing to the great amount of pelvic adhesions. The contents of the cyst were putrid and its walls quite rotten. The peritoneal cavity was washed out and drained.

Flatus passed thirty-two hours after the operation. The highest temperature recorded was 102°.

The patient made a rapid convalescence.

11

A. B., a medium-sized, brown-haired woman, aged thirty-six, widow, no family but there had been one abortion at six weeks. Her first visit to me was in April 1887, when the following history was elicited. Menstruation had always been irregular and painful, the flow being copious, and of late she had been gradually losing flesh. About twelve months back she had an attack of abdominal pain, which lasted for two weeks, and about the same time a lump was first noticed in her left side.

Examination showed the uterus to be enlarged,

and a swelling was detected to the left of that organ, about the size of an orange. The right ovary was enlarged and adherent behind the uterus.

The operation was simple. The right tumour was easily removed. There was some difficulty, however, in bringing the left ovary to the surface. The tube was considerably damaged and there was free hæmorrhage. No flushing or drainage was employed.

Flatus passed thirty hours after the operation. The highest temperature recorded was 101°.

The patient made a very good recovery, and went abroad at the end of five weeks perfectly convalescent.

13

A. M., a thin, anxious-faced woman with chronic skin disease on the face, aged fifty, married, has had six children and two abortions, the youngest child being ten years old. She came for advice in July 1888, on account of pains in her right side, beneath the lower ribs, but she had not noticed any swelling. Examination revealed a pulsating, fluctuating growth in front of, and closely connected with the uterus. There was dulness all over, and a souffle could be distinctly heard. The uterus moved independently of the tumour, and was retroflexed, with the cervix soft and os patent.

The operation was severe. The tumour was univer-

sally adherent and much difficulty was experienced in getting into the abdominal cavity. There was a broad, short, thick pedicle, and running into, and forming part of it, was a loop of small intestine, which had to be dissected away. The cyst was rotten in parts. The cavity was washed out with hot water and a drainage-tube inserted. Flatus passed forty-eight hours after the operation, and the highest temperature recorded was 102·6°.

The patient made a good recovery and was quite well in 1891.

14

M. P., a stout woman with iron-grey hair, aged sixty-one, married, has had four children and two abortions, the youngest child being twenty-seven years of age.

She was first seen by me in July 1888. Menstruation began at sixteen and was natural. There was a history of a fall some years ago, but she did not notice any bad effect resulting from it. Several months back she first noticed a swelling in her abdomen, which gave her pain, while at the same time she found herself growing thinner.

On examination, a movable fluctuating swelling was found in the abdomen, centrally situated, and in front of the uterus, which was pushed back and low down in the vagina, and could be moved independently of the tumour. There was dulness

over the swelling, and resonance in both loins and in the epigastric region.

The operation was somewhat difficult, the tumour dipping deep down into the broad ligament, out of which it had to be enucleated. Drainage was employed, the drainage-tube being removed on the third day.

Flatus passed thirty hours after the operation.

The patient made a good recovery. She was in excellent health in 1894.

15

C. D., a stout, brown-haired woman, aged thirty-nine, widow; has had three children and one abortion, the youngest child being ten years old.

She came to me for advice in February 1889. Menses appeared at the age of thirteen, the periods being regular but preceded by dysmenorrhœa. About two years ago her abdomen began to enlarge on the right side, and latterly she suffered pain. Micturition and defæcation were also painful. Examination revealed an irregular, fluctuating, movable swelling, rather to the right of the middle line. There was pulsation in the lower part. The uterus was behind the tumour, the cervix being hard, and os closed.

The operation was simple, the tumour, a multilocular cyst, being removed without difficulty. The

vessels in the pedicle were of unusual size. Drainage was not employed.

Flatus passed twenty-four hours after the operation. The highest temperature recorded was 101°.

16

A. W., a dark-haired, round-faced, well-nurtured woman, aged twenty-three, married, one child eight weeks old, was sent to me in April 1889. Menstruation commenced at the age of eleven, and had been quite natural. For the first four months of her pregnancy she was perfectly regular, and at the end of that time she noticed a swelling in her abdomen. Four days after her confinement her doctor discovered a tumour, which had since then been rapidly enlarging.

On examination, a large movable swelling was found in the right side of the abdomen, with distinct fluctuation in it. There was dulness over the tumour, and resonance elsewhere. The uterus was behind the swelling, and was enlarged and low down.

The operation was performed without difficulty, the tumour being a simple cyst.

Flatus passed twenty-six hours after the operation. The highest temperature recorded was 100°.

The patient made a speedy recovery and a male infant was born in 1890.

She is now in good health. 1896.

17

S. W., a short, pale-faced, dark-haired woman, aged fifty, widow, no children, one abortion, was seen by me in February 1890. Menstruation occurred at the age of thirteen, and the periods had been regular but scanty; the last one having taken place three years before. She had been always ailing, and for the last six years had been under treatment for dyspepsia. Three years ago she noticed her abdomen begin to swell, chiefly on the left side, and she complained of pain in her left loin.

Examination showed the abdomen to be enlarged, and mostly so on the left side. Fluctuation could be made out, and there was dulness over the swelling, which was freely movable, and resonance elsewhere. The uterus was in front of the tumour, and pushed forward; the cervix was soft.

The operation was simple, the abdominal adhesions being recent and easily broken down. The tumour was a multilocular cystic tumour of the left ovary, with a thick broad pedicle. It contained thick glairy fluid. Drainage was employed.

Flatus passed thirty hours after the operation. The highest temperature recorded was 100°.

The patient had a good deal of cystitis after the operation, but, on the whole, made an excellent recovery. She is now alive and well. 1896.

18

M. B., a tall, thin woman, with hollow cheeks and hectic flush, aged forty-three, widow, one child, twenty-three years old, came for advice in April 1890. Menses appeared at the age of fourteen, and were irregular and painful, the flow being copious. "She suffered from a chronic cough, and was unaware of the existence of a tumour, though twelve months ago she fancied she had felt something moving in her abdomen, but could not say which side she first noticed it in.

A central, regular, movable swelling was found in the abdomen, very large and tense. There was dulness all over, except far back in the flanks, and fluctuation could be felt per vaginam. The swelling was behind the uterus, which was pushed forward, and low down.

The tumour burrowed in the broad ligament and was enucleated, and the peritoneal cavity was washed out and drained. The cyst was thin-walled, with glairy contents.

Flatus passed forty-nine hours after the operation, and the highest temperature recorded was 102°.

The patient is now alive and well. 1896.

19

E. F., a short, brown-haired woman, aged twenty-three, single, was seen by me in May 1890. Men-

struation appeared at the age of fourteen, and had been quite regular, but painful. There was much emaciation. About eighteen months ago she had first noticed a swelling, but could not say on which side. Since that time her abdomen had rapidly enlarged, but was not painful, and as the swelling increased the dysmenorrhœa had diminished. On examination the abdomen was seen to be immensely and unequally distended, more so to the right side. There was dulness over the whole surface, even in both flanks, and fluctuation could be distinctly made out. There were evidently two tumours, a swelling in front of the uterus, and another to the left of and behind that organ, which was low down and pushed to the right side.

The operation was simple. Two large unilocular cysts were removed. There was no flushing or drainage.

Flatus passed twenty-six hours after the operation. The highest temperature recorded was 102·8°.

The patient made a good recovery, and was in perfect health in 1896.

20

M. D., a sallow-faced, black-haired, thin-featured woman, aged forty-seven, married, five children, the youngest twenty years old, came for advice in June 1890. The menses had appeared at the age of fourteen, and she was quite regular. The last period was

four years ago. Some time back she had noticed a small hard lump in her left side. It was painless, and grew slowly at first, but of late the swelling had increased rapidly, and she had difficulty in passing water. Examination disclosed a central, immovable, pulsating swelling; fluctuation could be detected, and there was dulness over the whole abdomen. The uterus was pushed forward and it was not free; the tumour could easily be felt behind, and at either side of it.

The operation was very severe. The tumour burrowed deeply in the left broad ligament, and was enucleated with great difficulty. The contents were colloid. The peritoneal cavity was washed out and drained. The tube was removed on the third day. Flatus passed twenty-four hours after the operation. The highest temperature recorded was 102·6°.

The patient made a good recovery, and was in excellent health in 1896.

21

M. S., a slight young girl, aged seventeen, single, was seen by me in September 1890. Menstruation commenced at the age of twelve, and was regular. There was no history beyond the fact that her abdomen was observed to be getting larger, while at the same time she was emaciating.

Examination showed the abdomen to be greatly distended, and pretty equally so. There was dulness

all over, and fluctuation everywhere. Per vaginam, two swellings could be felt, the one in front of, and the other behind the uterus, which was pressed forward.

The operation was simple. Two enormous unilocular tumours were extracted. There was no flushing or drainage.

Flatus passed twenty-four hours after the operation. Highest temperature recorded 103°.

The patient made a good recovery, and is now alive and well. 1896.

22

G. N., a little, wiry, shrunken woman, aged seventy-one, no family, one abortion twenty-six years before, came for advice in October 1890, on account of bladder trouble, being unable to retain her water. Menses appeared at the age of fifteen, and had been regular. "The last period occurred ten years ago." She was much emaciated, but had no suspicion of the existence of a tumour.

On examination, the abdomen was found to be swollen centrally, but not irregularly. There was dulness all over, except far back in the flanks, and fluctuation could be made out bimanually. The uterus was in front of the tumour, and bent forward, and could be moved independently of it. The operation was simple. A multilocular tumour of the left ovary was removed, with colloid contents. There was no drainage.

Flatus passed fifty hours after the operation. The highest temperature recorded was 101°.

The patient made a rapid convalescence, and was in good health when last heard of in 1894.

23

M. T., a thin, dark-haired woman, aged twenty-four, married, has had five children, the youngest being six months old. The menses appeared at the age of seventeen, and were quite natural.

She came to me in March 1891, on account of a swelling, which was discovered soon after her last confinement. It was first noticed in her left side, but there was pain in the opposite side. There were no other symptoms.

The abdomen was found to be enlarged to above the umbilicus. There was dulness over the swelling, and fluctuation could be made out. The tumour was in front of the uterus, and was fairly movable; its lower portion could easily be felt per vaginam.

The operation was simple. The tumour was adherent to the abdominal parietes, but was extracted without very great difficulty. Drainage was employed, the drainage-tube being removed on the second day. The tumour was a multilocular cystic growth.

Flatus passed fifty-two hours after the operation. The highest temperature recorded was 101·4°.

The patient made a good recovery.

24

C. L. aged thirty-two, married, six children, the youngest being fifteen months old, came to see me in July 1891. Up to the date of her marriage she had enjoyed good health, but had been more or less ailing during her subsequent pregnancies. The first labour was very tedious. The second was a face presentation, and she was attended by a nurse who "dragged the child away from her." During the last few months of this pregnancy she suffered from pains in the left side, similar symptoms being noticed during the third pregnancy. Throughout the fourth and fifth ones she had bad health, and suffered more or less from the same kind of pains, but they were not of so severe a character as in the earlier pregnancies.

Shortly after weaning her fifth infant, she met with an accident in jumping off a board, and was laid up for a week with great pain in her left side in the region of the kidney; there was, however, no blood passed in the urine at any time. For the first two months of her sixth pregnancy she had intense pain, which then suddenly ceased, and was not again noticed until after her confinement, when it once more made itself felt and troubled her from time to time. A few weeks before her visit to me another severe attack was experienced. The paroxysms were so severe that she writhed about, vomited, and had to be relieved by morphia injections. Since then they had recurred so frequently

as to be almost unendurable, and her medical attendant, knowing her to be pregnant, insisted on making an examination, which led to the discovery of a tumour. The patient then declared that for a long time she had noticed a swelling low down in the left side, but found that it changed its position immediately after an attack of pain.

On examination, the abdomen was found to be slightly enlarged below the umbilicus. In the left lumbar region a movable round swelling could easily be felt. It was not tender to the touch, or painful on pressure, but could be freely moved back into the left loin, down into the left iliac region, and across the abdomen to the right lumbar region. It could also be pushed up beneath the ribs on the left side, but it could not be brought in front of the uterus, nor could it be felt per vaginam. There was dulness half way to the umbilicus, and over the lumbar swelling, and elsewhere in the abdomen. The uterus was enlarged, the fundus reaching half way to the umbilicus and filling the pelvis. The body of the uterus inclined to the right side of the abdomen, the cervix being cushiony; the whole organ could be moved independently of the swelling. The vagina was dark-coloured, the breasts full, areola dark, and follicles enlarged. Urine amber-coloured, acid, sp. gr. 1020, phosphates, but no albumen. The tongue was clean, bowels regular, lungs sound, heart normal, pulse 88.'

The distinct history of the accident when jumping,

followed by pains in the loin, pointed to dislocation of the kidney, but the fact of there having been a swelling in the side for years indicated, rather, pelvic tumour of slow growth, possibly dermoid. Being doubtful of its nature, I determined to explore. On July 30, 1891, ether having been administered, I opened the patient's abdomen. An incision three inches long was made, beginning about an inch below the umbilicus. On opening the peritoneal cavity, a white glistening swelling was exposed and pushed forward towards the wound. It was tapped with trocar No. 2, and about a pint of dermoid fluid slowly escaped. The incision was then enlarged, and, more fluid being withdrawn, the tumour was extracted. It was now found that the pedicle was doubly twisted from *right* to *left*. In untwisting it an adhesion was separated, causing free bleeding at that part, so that it became necessary to draw that portion together by fine silk sutures. The pedicle was then transfixed. The other ovary, being small, was not interfered with. Very little sponging was required, as no fluid whatever had escaped into the peritoneal cavity. Silk sutures were used to close the wound, together with horsehair superficial sutures. The patient was very sick during the operation, and for some time afterwards, and brought up a quantity of bile.

The tumour contained hair and a tooth and about two pints of thick fluid.

Flatus passed fifty-one hours after the operation. The highest temperature recorded was 101°.

The patient returned home in September quite convalescent, and the wound perfectly healed. The pregnancy was uninterrupted, and the infant was born on the following January 11th; female.

Remarks.—It is probable that the tumour had been in existence for some years, and certainly throughout three pregnancies. It was only when the pedicle became twisted, however, that the real trouble began.

Subsequent History.—Female child born January 11, 1892. Labour normal. Infant perfect. Eighth child stillborn. Ninth child alive. The patient is alive and in good health, and is now some months advanced in her tenth pregnancy.

25

B. A., a dark-haired, thin-featured woman, aged twenty-five, married, has had eight children.

She was first seen by me in October 1891. There was no history previous to a tumour having been discovered after her confinement.

The abdomen was found to be enlarged centrally and unevenly. There was resonance in both flanks and in the epigastric regions, dulness elsewhere. Free fluctuation could be detected all over the tumour, which was in front of the uterus, and a broad pedicle was easily felt on the left side. The uterus was low down and pushed back, but quite free, with the cervix erosed.

The operation was simple. The tumour removed was a cystoma of the left ovary; the pedicle was doubly twisted. There was no flushing or drainage. Flatus passed fifty-two hours after the operation. The highest temperature recorded was 100·2°. The patient suffered from biliousness throughout her convalescence.

26

M. T., a short, fair-haired, pink-complexioned, woman, aged fifty, no children, came to see me in October 1891. She had good health in general, but eighteen years ago she was treated for neuralgic pains in the abdomen and kept her bed for a week or more. Latterly she suffered from pain in the left side of the abdomen, which was distended and hard, but the pain was not at any time very severe. She had no suspicion as to her condition until Dr. Stevens was called in to attend her on account of bad appetite, loss of flesh, and swelling of the abdomen. Up to that time she had been doing all her usual household work. Examination showed the abdomen to be irregularly enlarged. There was dulness all over, except in the flanks, and in the epigastric regions. Fluctuation could be felt over the entire swelling, but not as distinctly as might have been expected in such a large cyst. There was no tenderness, but evidence of adhesion was present. Per vaginam, fluctuation could be felt behind the uterus, which was pushed forward and to the right,

and which seemed to glide over the tumour from side to side, to a slight extent, but was not freely movable. The tumour, which was immovable, filled up the entire pelvis. The cervix was flattened and soft, and the os stenosed. The sound could be passed one and a half inches with great difficulty. Menstruation had been quite normal up to October, but the last period was very slight. There was some leucorrhœa. The urine was straw-coloured, sp. gr. 1001, no albumen or phosphates. She had no trouble in passing water, but the quantity had, of late, been more than usual. Her tongue was not clean; appetite had been bad for some time; bowels constipated. There was emaciation about the limbs and upper part of the body. The heart was normal; lungs sound; breathing somewhat impeded on lying down, and there was a slight cough at times. Pulse was fair, 80; arteries atheromatous. She slept well, and there was no headache or neuralgia.

The diagnosis was: "Large adherent cystic ovarian tumour, and, from its close connection with the uterus, probably burrowing in the broad ligament and likely to be a difficult case."

On November 3, ether was administered by Dr. Brinton, and, assisted by my colleague, Mr. Charles Morris, I opened the patient's abdomen. The omentum was adherent to the abdominal wall right down to the pubis, and the intestines were matted and universally adherent in front of the tumour,

much time being spent in separating them before it was possible to effect an entrance into the peritoneal cavity. The left tube was then peeled off, and the omentum separated, together with the intestines. On introducing my finger I found it impossible to penetrate high up into the abdomen because of the adhesions, and it was the same with regard to the pelvis. The tumour was seen to be in the left broad ligament, and extending right across the pelvis, behind the uterus. The intestines being separated from the front of the tumour, I punctured it with the large trocar, and withdrew some gallons of fluid. The opening in the cyst wall was then closed with forceps, and the intestine and omentum separated from the upper part of the tumour, and, as it was drawn forward, from the back of it. I next put forceps on all the bleeding points, and proceeded to enucleate the cyst from the right side. In doing so I found a second cystic cavity surrounded by large intestine. On separating this I saw that there was a pedicle from the right side of the uterus; this was secured, transfixed and cut across, thus liberating the right cyst. I then found that this part must be enucleated from behind the uterus, it eventually becoming apparent that it was continous with the cyst in the left broad ligament. The capsule could not be closed as the intestines were intimately adherent around it; I therefore fixed it into the wound, put in a glass drainage-tube and dressed with iodoform gauze. Considering the

nature of the operation the patient lost very little blood.

The tumour was a dermoid of the right ovary, burrowing behind the uterus, and deep into the left broad ligament. It consisted of two large cavities, containing twenty-six pints of thick, dark fluid, fatty matter, cartilage, bone, hair, skin, and mucous membrane, and was fused with the cyst on the opposite side. The specimen was shown at the O. S.

Flatus passed twenty-four hours after the operation. The highest temperature recorded was 101·6°. The drainage-tube was removed on the third day.

27

A. E., a short, putty-faced, strumous-looking woman, aged thirty, single, was seen by me in November 1891. She had always suffered from painful menstruation, but of late it had become much worse, quite hindering her work, as she was unable to walk, or even to sit up.

Examination disclosed a painful rounded swelling in the pelvis, about the size of a large orange, behind the uterus, which was retroflexed and fixed. The operation was severe, the tumour being covered by adherent intestine, and adherent to the floor of the pelvis. It was got out whole after much trouble. No drainage was employed. The tumour was a tubo-ovarian cyst.

Flatus passed eighteen hours after the operation. The highest temperature recorded was 102·6°.

28

H. C., a dark-haired woman, with down all over the limbs and body, and hair on the upper lip, aged twenty-five, single, was sent to me in December 1891. Menstruation had been irregular of late, and for some months she had not had a proper period. The urine was very scanty. She first noticed a swelling a month back, and went to see a doctor, who told her that she was pregnant. Fourteen days later she was seized with violent pains in her abdomen.

When she came to me the pain had almost ceased, but from the first her temperature was high, 100°. After a few days' rest, the temperature rose further, and she complained of pain in her left leg and thigh, which became swollen, but as the pain in the leg subsided, the abdominal swelling rapidly increased in size.

An ovarian tumour with twisted pedicle was diagnosed. The tumour proved to be adherent in front to the abdominal wall, and had ruptured high up, the abdomen being filled with thick slimy fluid. The cyst wall was rotten. Great difficulty was experienced in separating the posterior adhesions. The pedicle was twisted, soft, and œdematous, and three ligatures had to be tied before it could be

secured, as the silk cut through, and bleeding took place. Three times washing out was employed, and the cavity drained. An enormous quantity of fluid was withdrawn through the tube, which was left in for five days.

Flatus passed thirty hours after the operation. Highest temperature recorded 104·2°.

The patient made a good recovery, and is now alive and well in 1896.

29

Unruptured Tubal Pregnancy, with Cystic Tumour of the opposite Ovary. Operation followed by Mania and Phlegmasia Dolens. Recovery.

E. D., aged thirty-one, a short, stout, dark-featured woman, attended at the out-patient department of the Grosvenor Hospital in February 1892. She gave the following history. Healthy girlhood. Menstruation appeared at the age of eleven. The periods were regular, but she had much pain during the flow, which usually lasted for four days, and was never excessive. Married at twenty-seven; no family. Two years ago she had an attack of "inflammation in the belly," and was admitted into a London general hospital. When there, she was told she had a tumour, but nothing further being done, she left that institution and went home.

She had been in good health and quite regular up to Christmas 1891, at which date her last period occurred. Soon afterwards she began to feel ill, and had attacks of sickness throughout the month of January. On the evening of February 10, she was suddenly seized with acute pains in the abdomen, and had attacks of sickness and faintness during the night. Turpentine stupes were applied, and gave some relief, and the pain passed off towards morning. Her doctor was then sent for, and he attended for three days, during which time she was kept in bed. At the patient's request, however, he discontinued his visits, but two days later, in consequence of a second attack of a similar nature, he was again called in, and remained in attendance for four days, the patient being kept in bed, and under the influence of morphia. At the end of that time she got up, and not being satisfied about her condition she came to the Grosvenor Hospital, where she was seen by my colleague, Dr. Gibbons, who strongly advised her to come into the hospital. Two days later she was admitted under his care.

Condition on admission.—Bimanual examination revealed the uterus pushed forwards, and to the right side, the body being enlarged, and the cavity measuring three and a half inches. Cervix soft; os patulous. Behind the uterus, and filling up the left side of the pelvis, was an irregular swelling, baggy to the touch, somewhat tender on pressure, and reaching to the right side of the uterus, where

another swelling, round, and about the size of a cricket ball, could be felt fixed in Douglas's pouch.

Defæcation and micturition had both been painful and difficult of late. Urine acid, sp. gr. 1005, clear, no albumen. There had been an intermittent discharge of blood since February 17. On March 1, a small piece of fleshy substance was passed per vaginam. Dr. J. Bland Sutton was kind enough to examine the specimen, and pronounced it to be decidua. On March 4, a larger portion was passed, after much suffering, and next day an almost complete cast of the uterine cavity was expelled. The patient was seen in consultation by Dr. Gervis, and there being no doubt as to her condition, she was transferred to my wards for operation on March 7, and on the following morning, ether having been administered, I opened her abdomen.

The abdominal walls were very fat, there being quite three inches of adipose tissue above the muscles, necessitating an incision five inches in length. There was no fresh blood or blood-clot, either in the abdominal or pelvic cavity. The left Fallopian tube was enlarged to the size of a German sausage, and it was intimately adherent to some coils of intestine, to the floor of the pelvis, and to the back of the uterus. Its fimbriated extremity was spread out over, and adherent to, a cystic tumour occupying the right side of the pelvis, which proved to be an ovarian cystoma fixed in Douglas's pouch by old adhesions. The Fallopian tube was

separated with some difficulty from its surroundings, and brought unruptured to the surface ; but just as the pedicle-needle had been passed, the patient coughed and strained, and the needle cut through the tube, the contents escaping into the abdominal cavity. Some smart hæmorrhage occurred at this moment, and the elastic ligature was immediately put round the uterus. I then transfixed and tied the left uterine cornu, and top-sewed the wound with fine silk. The elastic ligature was then loosened, and, there being no more bleeding, it was removed. The ovarian tumour was next removed, together with its corresponding tube. The abdominal cavity was then well flushed out with warm water, but no fœtus was observed at the time, and a second flushing out being required, the contents of the first receptacle were emptied out, thus preventing further search. A glass drainage-tube was placed in the lower end of the abdominal wound, which was then closed with silkworm-gut sutures, and covered with ordinary gauze dressings. Owing to the trouble caused by splitting of the tube, and the consequent amount of time spent in repairing the damage, the operation was prolonged to just over two hours and a quarter, but the patient when removed to bed recovered rapidly from the shock, and had no sickness.

Previous to the operation it was recognised that she would give some trouble, because of her violent temper, but we hardly expected anything

like that which occurred during her sojourn in the hospital. From first to last, eight nurses in succession were exclusively occupied in watching this woman, but one by one they were tired out, and retired from the case. There was no history of drink ; on the contrary, the patient was said to be a sober, hard-working woman, but very excitable and quick tempered.

On the day following the operation the patient became very restless and noisy. She rolled about in bed, and screamed at the top of her voice. She seemed to be hysterical, and could not be made to lie still, though for her safety, thigh-straps had been employed, and a nurse stationed on each side of the bed to control her movements. Twenty drops of tincture of opium were administered twice within three hours, but failed to produce even drowsiness. In the morning she developed a hard cough, but there were no chest symptoms, and no pain on either side. Respirations 36 ; temperature 101° ; pulse 120. Urine plentiful, clear, and without any trace of albumen, sp. gr. 1017.

March 10th.—She had a bad night, and was very tiresome. Slept but little, and towards morning became wildly excited and resumed her screaming, and was very noisy all day. Her cough was very troublesome, and the respirations were still 36 to the minute ; pulse 110 ; temperature 100·6°. No pain in chest, but she complained of backache low down. Saline expectorant ordered and thorax poulticed.

Opium discontinued because of cough. Flatus passed freely at midday. Mental condition much worse in the afternoon. She rolled about in bed, and yelled at the top of her voice like a madwoman, and by her movements frequently displaced the drainage-tube and dressings. As the glass tube had become a source of danger and was useless, it was removed, and twenty grains each of bromide of potassium and chloral hydrate were given by the rectum.

March 11th.—Patient was awake most of the night, and was extremely troublesome during the day. She did not wander or mutter, but simply screamed and roared, and would not keep still, in spite of all her nurses could say or do. It was evident that she was not responsible for her actions, and could not be left alone for a moment. The cough was better, and there was no albumen in the urine. Pulse 118, and full; temperature 100·4°; respirations 32. Thirty drops of tincture of opium were given with the feeding enema at night, and the patient had several short intervals of sleep.

March 12th.—Cough much better. Respirations 22; pulse 88; temperature 99°; urine normal. Patient was still tiresome, but, on the whole, more reasonable and better behaved. Abdomen soft and flat, and the wound healing well. Bowels opened by enema of soap and water. Opiate at night.

March 13th.—She had a good night and slept fairly well. Looked much brighter in the morning,

and was surprisingly quiet. Complained of stomach-ache, but the condition was all that could be desired. Pulse 100; temperature 100°; respirations 20; urine normal. Mental condition much improved.

March 14th.—She slept well during the night, and was much better in the day. The cough had quite disappeared. Respirations 18; pulse 96; temperature 190°. Lowest suture removed. Wound looking well. Opiate at night.

March 15th.—She had rather a sleepless night, but dozed towards morning, and was very good all day. Temperature 100·2°; pulse 90. Opiate given at night. Took nourishment well by mouth.

March 16th.—She slept fairly well, but complained to-day of great pain in the lower part of her abdomen. Two more stitches were removed, and in each instance a drop of pus exuded from the stitch-hole. Pulse 112; temperature 100·8°. Patient appeared to be exhausted, and lay on her back all day. She was rather sulky, but very quiet, and took her food in fair quantities. Five grains of quinine were given by mouth, and the usual opiate at night.

March 17th.—Patient had a very restless night, and did not get any sleep. She complained to-day of abdominal pain, which was, however, relieved by passing the flatus-tube. Two more sutures were removed, and again pus exuded from the stitch-holes. About noon the patient complained of severe pain in her left ankle, and said it prevented her sleeping. There was nothing in the way of swelling

or redness about the ankle, but the temperature went up to 101·6°, and the pulse to 120. Hot fomentations were applied to the ankle, and the night draught was increased by ten minims.

March 18th.—She slept but little during the night, and in the day was very restless and inclined to be noisy and troublesome. The pain in her ankle was gone, but she complained of backache, and severe pain low down in her abdomen. Four more sutures were removed from the wound, which looked well united. In the evening she again complained of much pain in her ankle and calf of leg. The limb was raised on a pillow, and after her opiate she went to sleep and had a fair night. Pulse 112; temperature 101°.

March 19th.—In the early morning the patient began to be noisy and troublesome, and by noon had one of her maniacal outbursts in full play; rolling about in bed and screaming loudly. Morphia was then resorted to, but with little or no result, and after a fatiguing day, during which she gave her nurses no rest, she became quiet and dozed off, waking up now and again with a fresh outburst of screaming. Pulse 120; temperature 101.

March 20th.—She had rather a poor night, and to-day felt bilious and cold, and vomited quantities of green fluid. Hot water and bicarbonate of soda were freely administered with good effect. In the afternoon she became extremely troublesome and screamed and jerked her legs

about. An opiate was given, and her left leg secured to a pillow and poulticed. Pulse 100; temperature 100°; urine normal.

March 21st.—She had a very bad night, and lay awake, making the hospital ring with her screams, much to the horror of the other patients. The left leg was now swollen and hard, and the pain was acute behind the knee and in the thigh; but as yet the upper part of the limb was soft. The bowels were opened by enema, and much hard fæcal matter was evacuated. Tongue coated; pulse 120; temperature 100°; no albumen in urine.

March 22nd.—Patient slept, off and on, throughout the night, but was still restless in the morning and complained of acute pain in her left thigh, the lower part of the limb being much easier. A slight amount of pus exuded from the stitch-holes. Temperature 99·6°, pulse 102; urine normal. The whole of the left limb was now swollen and hard.

March 23rd.—The patient was better this day and much quieter. She took her nourishment well and slept soundly. Mentally there was a marked improvement. Temperature 99·2°; pulse 90; bowels regular. The limb was still hard and swollen, and extremely painful when moved.

March 24th.—Patient again inclined to be troublesome and noisy. There was less pain in the limb, which was somewhat softer. Poulticing discontinued, and the limb bandaged. Five grains

of quinine given by mouth, and a tablespoonful of brandy every four hours. Opiate at night.

March 25th.—She had a very good night, and during the day was free from pain. Temperature 99·2°; pulse 98; bowels open, and urine normal.

March 26th.—The left leg was very painful behind the knee and in the calf; the ankle also was again swollen and hard. Poultices resumed, and opiate at night.

March 27th.—Patient improving mentally and bodily. Temperature 99·6°; pulse 96.

March 28th.—Restless again to-day and tiresome. Complained of severe pain behind the knee and in her ankle, though the limb seemed less swollen. In the evening she was seized with acute pain in her right leg, which kept her awake in spite of a night draught. Temperature 99·6°; pulse 100. Limb raised on pillow.

March 29th.—The right leg was very painful to-day, and began to swell. Patient complained of backache, and was in very low spirits. Pulse 100; temperature 98°.

March 30th.—Right leg very painful and much swollen. Bowels opened by enema. Temperature 100°; pulse 100.

March 31st.—She had very little sleep, and complained bitterly of acute pain in her right thigh and leg. Was sick this morning. Pulse 110; temperature 100·4°.

April 1st.—Patient's mental condition showed marked improvement during the last week, and she behaved like a reasonable being, though at times she inclined to her old habit of screaming without any apparent cause. The right limb was much swollen, hard, and painful when moved. Temperature 100·6° ; pulse 108.

April 4th.—Much better in every way. Right limb less swollen and not so painful. Temperature 99·6°.

April 10th.—Stronger, and improving every day. Slight backache and pain in the right limb.

April 26th.—Limb bandaged, and pillow removed. Mental condition much changed for the better. She was obedient, contented, and remarkably quiet.

May 5th.—Quite convalescent. Temperature and pulse normal. Some stiffness remained in both limbs, which were still bandaged.

February 1894.—Patient in good health, and able to perform all her household duties.

May 27th.—Patient in perfect health mentally and bodily.

Remarks.—This case seems to me to have been one of septic mania, due to absorption of pus from the abdominal wound. The mental symptoms were in full swing for some time before the phlegmasia dolens appeared, and the latter would seem to have been in a great measure brought about by the patient's wild movements immediately after her operation.

30 and 34

E. W., a thin, dark-haired woman, aged twenty-four, married, no family, consulted Dr. Seccombe, of Terrington, Norfolk, in March, 1892, on account of pains in her stomach, which were at first thought to be due to flatulence. A tumour was discovered, which was diagnosed, in consultation with Dr. Plowright, of King's Lynn, to be an ovarian cyst. The patient was sent to the Samaritan Free Hospital, and admitted under my care on April 30, 1892.

The following history was elicited from her :

Menstruation first appeared at twelve years of age, and since then the periods had been regular, though scanty. She had been married two and a half years, but had not become pregnant. In June 1891, she had influenza, and in the following August very nearly succumbed to an attack of measles, which left her in a delicate state of health. Her first experience of abdominal pain occurred in February 1892, and as it became worse she sought medical advice.

On admission, the patient, who was much emaciated, flushed, and feverish, complained of great tenderness in her abdomen, and was evidently suffering from extreme distension, the circumference at the umbilicus being 48 inches. Her breathing was rapid and shallow ; pulse 120 ; temperature 101° ; tongue coated ; urine acid, sp. gr. 1015, clear, and no trace of

albumen. The abdomen was œdematous and the vulva and thighs swollen. Her appetite was fair, but she had been losing flesh steadily for the last few months. Of late she could not lie on her right side because of a dragging pain in her abdomen to the left of the navel.

The abdomen was distended by a tense swelling, which fluctuated freely. There was dulness up to the ensiform cartilage, and in both flanks. The tumour was adherent to the parietes. Vaginal examination showed that the uterus was behind the tumour, which almost filled the pelvis. The uterine cavity measured 2½ inches, and the uterus could be moved laterally.

On May 4 Mr. Stormont Murray administered ether, and assisted by my colleague, Dr. Rutherfoord, and in the presence of Dr. Seccombe and other visitors and colleagues, I opened the patient's abdomen, separated the parietal adhesions, and tapped the tumour, thirty-four pints of dark viscid fluid being drawn off. After a tedious operation, owing to the universal adherence of the cyst in the abdomen and pelvis, I succeeded in removing the tumour, the pedicle of which was doubly twisted and adherent to the large intestine. The right ovary was then brought to the surface and carefully examined, and as it appeared to be healthy and was not enlarged, it was returned into the abdomen. The peritoneal cavity was then washed out and a drainage-tube inserted, and the wound closed with silkworm-gut sutures.

The patient made a good recovery, though the pulse never reckoned less than 120, and temperature kept above 100°, till the end of the second week. She left the hospital on June 4, and went to her home, where she remained in good health up to November 1892, when she became pregnant. Her health was excellent up to July 20, 1893, at which date she was delivered of a stillborn male child which weighed over 11lb. The presentation was a breech, and the labour very tedious. The child was alive at the commencement of labour, but owing to its unusual size, and the marked deficiency of expulsive power, notwithstanding the administration of ergot, it was impossible to save its life. The placenta came away easily, and the patient went on well and got up on the eleventh day. It was remarked after delivery that the mother was as slight as ever she had been, and Dr. Seccombe is confident that no swelling other than the contracted uterus could be detected in her abdomen. On the fifteenth day, however, when up and about, she had an attack of pain in her right side, which compelled her to go back to bed, where she remained for a couple of days, when the pain passed off and she thought no more about it. A month after her delivery she noticed that her abdomen was rapidly becoming enlarged, and later on she sent for Dr. Seccombe, who examined her and found a large cystic swelling on the right side of her abdomen. He wrote at once to me, and on September 1, 1893, I saw the patient with him

and confirmed his diagnosis. It was decided that the case should wait till October, when she could come into the hospital. She was brought to town on October 4, and re-admitted. I found that the tumour had increased so rapidly in the month as to double its size. There was also much free fluid in the peritoneal cavity, and the patient had again emaciated, and was even in a worse condition than when she came up for the first operation.

On October 6, the patient was chloroformed by Mr. Murray, and assisted by my colleague Dr. Bantock, Dr. Seccombe and others being present, I opened the abdomen, and disclosed a dark-coloured swelling, which was adherent to the abdominal parietes and covered by adherent omentum in its upper part. These adhesions were separated and the tumour tapped, thirty pints of dark thick fluid being withdrawn. It was then seen that the tumour had burrowed into the broad ligament and had passed across in front of the uterus, between that organ and the bladder, completely stripping off the peritoneum from the anterior surface of the uterus. This portion of the tumour was enucleated, and the broad sheet of peritoneum in front of it tied in four pieces, cut across, and dropped back into the peritoneal cavity. The rest of the cyst was then separated from the surrounding adherent intestine, and the pedicle transfixed and tied. The tumour having been cut away, the abdominal cavity was thoroughly washed out and drained. The peritoneum was next

dissected off for about an inch round the incision, and the scar tissue cut away. The wound was then closed with three layers of sutures—a continuous suture of thin catgut for the peritoneum, interrupted sutures of thick catgut for the aponeuroses, and silkworm gut for the skin. The patient made a rapid recovery and went out on November 4, quite convalescent.

Curiously enough, after the second operation the pulse and temperature kept above 120 and 100° respectively for the first fortnight, this condition being due to a small abscess in the lower angle of the wound where the tube had rested.

Remarks.—This is the only instance in which I have met with an ovarian tumour burrowing in front of the uterus and displacing the peritoneum between that organ and the bladder; in other words, completely stripping off the peritoneum from the anterior surface of the body of the uterus. Tumours burrowing behind that organ and raising the peritoneum from its posterior surface are not infrequently met with, but the former condition is, I believe, uncommon. It is not often that the growth of an ovarian tumour can be dated with any degree of certainty, but in this case it is a fact that, so far as one could judge by sight and touch, the right ovary was healthy on May 4, 1892. Dr. Seccombe states that after the patient's delivery in July 1893, no swelling other than the contracted uterus could be felt in the abdomen. A fortnight later the patient

had severe pain in the right side, and about a month or six weeks after her confinement her abdomen began to get big, when, on examination, a cystic tumour was discovered, and this growth increased so rapidly that when seen a month later it was as large again. I presume the disease started during pregnancy, and that after delivery, the pressure having been removed, the growth rapidly developed, as such tumours usually do under similar circumstances. The first tumour was a large multilocular growth with dermoid material in parts. The second tumour was very similar as regards size, fluid contents, and, so far as one could judge from the history, in the duration and rapidity of growth, but no dermoid material was observed in it.

31

S. T., a short, thin-faced, grey-haired woman, aged fifty-two, single, came for advice in June 1892. Menstruation had ceased two years before. In October 1891, she first noticed a swelling and was told by her doctor that she had a tumour. He tapped it, withdrawing fifteen quarts of fluid. In the following March she was taken ill with inflammation, and "stoppage of the bowels," and had to keep her bed for a month. She had, in all, three attacks of peritonitis.

Examination revealed a swelling, almost central, but if anything, more to the right. It was fixed in

the pelvis, and could not be moved from side to side. There was dulness over it, and fluctation could easily be detected. The uterus was pushed low down behind the tumour.

The operation was severe, the tumour being universally adherent. The pelvic adhesions were especially troublesome. The pedicle was twisted. No flushing or drainage was employed. Flatus passed sixteen hours after the operation. The highest temperature recorded was 101·4°. The patient made a good recovery and is now alive. 1896.

32

Pregnancy complicated by two Ovarian Tumours; Miscarriage; subsequent Removal of two Gangrenous Dermoids. Recovery.

In May 1892, Dr. Ensor, of North Kensington, was called in to see a woman aged thirty, who had suddenly been taken ill with excruciating pains in her abdomen, and who was supposed to be miscarrying. He examined her, and finding "an abdominal swelling and an unusual pelvic condition," sent her to the Samaritan Hospital, where she was admitted under my care. The patient was a slender, light-haired woman of medium height, who appeared to have gone through much suffering, the body, limbs, and face being much emaciated.

History.—She had been married twelve years, and was the mother of two children, besides which she

had become pregnant three times within three years, but in each pregnancy had aborted about the third month, the last occasion being two and a half years ago. Her second infant died soon after its birth, and she was in bed for over a month with inflammation of both breasts, followed by "peritonitis." Ever since that time her health had been bad, and for two years or more she had been losing flesh. In October 1891, an attack of rheumatic fever kept her in bed for five weeks. For over a year she had suffered from pains, which always seemed to start from the lower part of the abdomen on the right side. For some months she had noticed a swelling in her left side, and had complained of tenderness there.

Condition on admission: Appetite bad, tongue foul, bowels constipated, skin dry, temperature 100°, pulse 115, heart sounds normal, lungs healthy, urine acid, specific gravity 1010, no albumen. Mammæ swollen, areola dark, follicles enlarged, and serum in both breasts. Amenorrhæa three months. No sickness or retching, but pain of a stabbing character, deep in her abdomen and extending to both sides, was always present, and the slightest movement added to her sufferings.

The abdomen was irregularly enlarged by a swelling, which extended from below the ribs on the left side to the right iliac region, crossing the middle line below the umbilicus. The tumour was movable and tender on pressure. No fluctuation, pulsation,

souffle, or contractions were detected in it. There was dulness on percussion over the space occupied by the tumour, but resonance elsewhere. Just above, and to the right of the umbilicus, was a tender spot where crepitation could be felt, pointing to adherent omentum or intestine. Bimanual examination revealed the uterus pushed upwards and forwards, its cervix lacerated and cushiony, lying behind the pubes, with the os patulous, and a glairy discharge exuding from it. Behind the uterus was a swelling which filled Douglas's pouch, the body of the uterus being wedged between it and the lower portion of the abdominal tumour. There was no discoloration about the vagina.

My diagnosis was : "Pregnancy two and a half to three months, complicated by two tumours, the abdominal one ovarian, and that in the pelvis probably a dilated Fallopian tube." The patient, however, insisted that she was not pregnant, as she had not experienced the feelings which had accompanied her former pregnancies, but admitted that her periods had never before stopped unless when pregnant. She was seen in consultation by most of my colleagues, and it was suggested by a high authority that the patient should be carefully watched for a while. Accordingly she was kept at complete rest in bed. A fortnight later it was noticed that the pelvic condition had undergone a considerable change, the uterus being pushed completely out of the pelvis by the tumour in Douglas's pouch, which had suddenly

increased in size. The cervix uteri was now above the pubes, the os pointing directly forwards. The lower part of the uterine body could just be felt by vaginal examination, but no idea of its size could be formed because of its situation between the two tumours. After many lengthy consultations and careful examinations it was agreed "that the best thing for the patient, if pregnant, would be to empty the uterus, for the pelvic tumour was enlarging at such a rate as to threaten danger by blocking up the pelvis."

Accordingly, on May 30, a sound was passed through the cervical canal to the extent of four inches. Within the next few days there was no change in the patient's condition, and on June 4, urgent domestic affairs necessitating her presence at home, she left the hospital, with the intention of returning in two or three days.

On June 12, after a fatiguing journey in an omnibus, she was "taken queer" on reaching her home, and on the following morning, a three and a half months' fœtus in its membranes was expelled. Ten days later she got up and set about tidying her room. The same evening, however, she was seized with violent abdominal pains and vomiting. Dr. Ensor attended and kept her in bed till she could be removed to the hospital, where she was readmitted on June 28.

Her condition then was as follows: Temperature 101°, pulse 120, tongue dry and coated, bowels con-

stipated, face flushed, breathing short and catchy, abdomen distended and tender all over, both tumours fixed and much enlarged.

Again delay was advised, as her journey to the hospital had brought on sickness and exhaustion.

On July 7, ether having been administered, I opened the patient's abdomen. A dull, dark-coloured tumour, adherent to the peritoneum in the line of incision, presented itself, and much difficulty was experienced in removing it. The pedicle was found to be strangulated by a double twist from within out, or from right to left, both tumour and pedicle being in a gangrenous condition, and leaving but little sound tissue wherein to transfix and tie the ligature. The right tumour, covered by matted intestine, was firmly wedged in the pelvis, and was adherent to the back of the uterus, so much so that I had grave doubts as to the possibility of its removal, but this was at length accomplished after a tedious process of enucleation. The tumour and its pedicle were in almost exactly the same condition as that found on the opposite side, but in this instance the "gangrene" had extended even closer to the uterus, and it was found necessary to enclose some uterine tissue in the ligature. The abdominal cavity was then well washed out, a drainage-tube inserted, and the wound closed with silkworm gut and dressed with simple gauze. The double twist in the pedicle on this side was from without in, or from right to left. Both tumours were dermoids, the left being

much larger than the right. The patient when put back into bed had a very fair pulse, considering the severity of the operation and her feeble condition previous to it. I fully expected to have some trouble with the after-treatment, but she rallied quickly, had no sickness to speak of, and made an excellent recovery.

Remarks.—Judging from the history of the first attack of abdominal pain and vomiting, my impression is, that rotation of the tumour on the right side had taken place prior to her admission into the hospital. I judge this also from the condition of the pelvic adhesions, which were certainly not so recent as those connected with the other tumour. The latter may have rotated when the labour came on, but the severe and prolonged abdominal pains, which suddenly set in ten days afterwards, point, I think, to strangulation of the pedicle on the left side, or, it may be, of both pedicles. Had the patient's abdomen been opened earlier, the operation would have been much easier, and the pregnancy might have gone on to full term. As it happened, the woman's life was placed in great jeopardy by the delay. However, it is easy to appear wise when an operation is over and the patient convalescent. I may say that the difficulties met with prior to the operation can only be rightly estimated by those who examined the woman. No such obscure case has come under my notice within the last ten years, and it seems to me to be particularly instructive, showing as it does the difficulty of

forming a correct diagnosis where one or more tumours exist in the abdomen.

The patient is now in excellent health.

33

M. W., a pale-faced woman, aged fifty-seven, married, has had seven children and one abortion, the youngest child being thirteen years of age. She came for advice in July 1893. Menstruation had never been excessive, and the last period occurred between ten and eleven years ago. I could find no history, except an attack of pain which had lasted for two days, but did not prevent her getting about. Examination showed the abdomen to be centrally and unevenly enlarged. The swelling was elastic to the touch, but not fluctuating. There was resonance above the tumour, and in both flanks ; no pulsation. The cervix was below the tumour, the base of which could not be felt per vaginam.

The operation was simple, the cyst being extracted without difficulty. The tumour was a multilocular papilloma of the right ovary. There was no drainage.

Flatus passed forty-five hours after the operation. The highest temperature recorded was 100·8°.

35

E. L., a short, full-faced, high-coloured girl, aged sixteen, single, was seen by me in November 1893.

Menstruation had been quite regular, but the loss was free. Eighteen months before her visit an abdominal swelling was first noticed, but there was no pain, and no loss of flesh. On examination, a central abdominal swelling was found with free fluctuation throughout, and dulness all over the abdomen, except in the right loin. The uterus was behind the tumour. The operation was quite simple, there being no adhesions. A left ovarian cystoma was removed. Flushing and drainage were not employed.

Flatus passed twenty-four hours after the operation, and the highest temperature recorded was 101·2°.

The patient is alive and well. 1896.

36

R. M., aged twenty-seven, widow, no family, came for advice September 1893. For years she had suffered from severe pain in both sides of her abdomen, particularly about the time of the periods, which were excessive and painful. She had lost flesh rapidly within the last six months and had become so weak that she had to give up work and take to her bed.

Bimanual examination revealed considerable enlargement of both ovaries; that on the left side being cystic and adherent, whilst the right was as large as a Tangerine orange and freely movable.

The operation was somewhat tedious owing to the adhesions, which bled freely. The left ovary

burst during extraction and some of the gelatinous contents escaped into the pelvic cavity. The right ovary was removed whole and consisted of a thin-walled cyst containing clear glairy fluid. Drainage was employed for thirty-six hours.

Flatus passed in forty-eight hours. The highest temperature recorded was 101·8°.

The patient made a rapid recovery. She is now alive and well. 1896.

37

E. L., a tall, pale-faced, anæmic woman, aged thirty-five, single, was seen by me in April 1893. For the last two years she had been suffering from severe pain in both iliac regions and from sickness. The pain became worse both before and during the periods.

Examination disclosed a swelling at each side of the uterus, which was retroflexed. The ovaries were baggy to the touch, enlarged to about the size of a bantam's eggs, and fixed.

The operation was simple. Both ovaries were adherent and quite useless, the right being a large cyst, the left riddled with cysts containing fluid. Both were removed. Drainage was not employed.

Flatus passed fifty-two hours after the operation. The highest temperature recorded was 101·2°.

The patient is now alive. 1896.

38

E. W., a pale-faced, extremely quiet mannered woman, aged twenty-two, single, came for advice in January 1894. Menstruation had been quite regular, the flow of late lasting a week, and being accompanied by some pain. For two years she had been suffering from pain in her right side, but had no idea that she had a tumour until she was told so.

On examination, the abdomen was seen to be centrally and evenly enlarged. There was dulness all over the front, and in both flanks, and very free fluctuation could be felt. The cyst was not at all tense though very large. There was complete procidentia, with cystocele, and rectocele.

The operation was simple, the adhesions being recent and easily broken down. The wound was less than two inches long. No flushing out or drainage was employed.

Flatus passed fifty hours after the operation. The highest temperature recorded was 101.2°.

The patient made a speedy convalescence and is now alive. 1896.

39

E. R., a pasty-faced woman, aged twenty-nine, married, no family, was seen by me in February 1894. Menses appeared at the age of fourteen, and she had suffered from dysmenorrhœa. For some

time past she had had great pain in the right iliac region, and swelling of the leg on the same side. Her abdomen had become enlarged, and she was unable to work, or stand, or get about. Pelvic examination revealed a swelling on the right side, close to the uterus, and about the size of a cricket-ball. The cervix uteri was elongated and the os stenosed.

The operation was severe. The tumour was removed with much difficulty, and proved to be a tubo-ovarian cyst of the right side, the ovary on that side being a complete shell, with the tube opening into it. Drainage was employed, the tube being left in until the sixth day.

Flatus passed twenty-four hours after the operation. The highest temperature recorded was 102°.

The patient made a rapid recovery and is now alive. 1896.

40

E. P., an iron-grey-haired woman, aged fifty-six, married, has had nine children and three abortions, the youngest child being thirteen years of age.

She came to me for advice in June 1894. Menses appeared at the age of sixteen, and had always been quite regular, but somewhat painful, the flow being free. Since the age of forty-seven the loss had been very great, and of late she had been losing flesh. Examination revealed a tumour lying in front of the uterus, and extending to above the umbilicus.

In its lower part, which was very hard, pulsation could be felt through the abdominal wall. The uterus was freely movable, the cervix split, and os patent. The diagnosis arrived at was: "Ovarian tumour, with secondary growth, probably fibroid."

The operation was difficult, the cyst being adherent. On extracting it, a large, hard tumour came in view, which proved to be a sarcoma, or fibro-sarcoma, invading the lower part of the cyst. This growth was very vascular. Drainage was employed, the drainage-tube being removed on the third day.

Flatus passed fifty hours after the operation. The highest temperature recorded was 101·2°.

The patient made a rapid recovery and is alive. 1896.

41

E. C., aged fifty, married, one child aged six years. She had been under notice for some years. There was a history of a fall before she married. She had had eight abortions. Her periods were never free, but after some of the abortions secondary hæmorrhage set in, and she lost much blood. There was marked emaciation, and she had attacks of pain from time to time, which compelled her to stop in bed.

The tumour seemed to change its shape frequently and had been increasing rapidly of late.

The abdomen was much distended and very tense

all over, with free fluctuation throughout. There was dulness over the swelling, and resonance in both flanks, and in the epigastric region. The uterus was behind the tumour, the right portion of the latter being hard. The diagnosis arrived at was: "Fibro-cystic, or ovarian tumour."

The operation was difficult, the tumour being very adherent, and there was free hæmorrhage, during the separation of the adhesions. The pedicle was six inches broad, short, and close to the uterus. The tumour was multilocular.

Flatus passed fifty-two hours after the operation. The highest temperature recorded was 102·4°.

The patient made a rapid recovery. She is now in good health. 1896.

42

M. A., a very thin, medium-sized woman, aged thirty-five, married, one child aged thirteen years, was seen by me in July 1894. Menses appeared at the age of fourteen, and were quite regular, accompanied by slight pain. About three months before her visit she first noticed that her abdomen was getting larger, but she had had pain in it and in both thighs for a longer period.

On examining the patient the swelling was found to extend beyond the umbilicus. There was resonance in the right flank and above the navel, and fluctuation was fairly distinct. The uterus was

completely fixed and surrounded by the swelling, which spread out laterally and posteriorly.

The diagnosis was: "Broad ligament tumour." The operation was very severe. On opening the abdomen the tumour was found to be adherent to the parietes. The walls of the cyst were red, very vascular and thin, so much so, that one could see flakes floating within the cyst. It was tapped with a small trocar, and some pints of dark, flaky fluid were drawn off. The tumour being firmly adherent in the pelvis, I opened the cyst, and emptied it of its semi-solid contents. The bleeding was copious, and much time was spent in arresting it. Two drainage-tubes were employed; one in the abdominal cavity, the other in the cyst, the walls of which were then stitched to the abdominal wound. Flatus passed fifty hours after the operation. The highest temperature recorded was 102°.

The patient made a good recovery and is now alive. 1896.

43

S. P., a short, thin, quiet woman, aged forty-two, single, was seen by me in October 1894. She had suffered from dysmenorrhœa, and when thirty years old the menses had stopped for one year. For five or six years she had suffered from abdominal pain, which had become intensified during the last two years, and of late she had been losing blood from the rectum.

Her abdomen was found to be greatly distended. There was dulness over the swelling which fluctuated freely, and resonance in both flanks. The tumour was behind the uterus, which was pressed forward.

The operation was severe, the tumour being adherent to the abdominal walls, omentum, intestine, and mesentery. The pedicle was twisted. The right ovary was cystic; both were removed. Drainage was employed, the drainage-tube being removed on the third day. Flatus passed fifty-two hours after the operation. Highest temperature recorded 101·2°.

The patient made a good recovery.

44

A. S., a dark-featured woman, aged twenty-two, single, came for advice in October 1894. There was nothing unusual about her menstrual history. Some months ago she first noticed a swelling in her abdomen, and suffered constantly from pain. Of late there had been some loss of flesh. Examination revealed the uterus enlarged, with its fundus bent forward. To the right of this organ was an elongated swelling, which appeared to be fixed. Above the pubis, and to the right of the middle line, the body of the uterus could easily be felt through the abdominal wall.

The operation was severe, the tumour being adherent to the pelvis, and the intestines being matted above it. No drainage was employed.

Flatus passed twenty-four hours after the operation. The highest temperature recorded was 102°.

The tumour was a cystoma of the right ovary.

45

E.D., a tall, thin, flushed-faced woman, aged forty, married, has had four children, the youngest being three and a half years old. She was seen by me in October 1894, and gave the following history. Menses at the age of fourteen, regular, dysmenorrhœa. Seven years ago, before the birth of her second child, she had an attack of pain on the right side, which she never quite lost, but it became somewhat less severe until her third pregnancy, when it again increased, and became worse just before her confinement. For the next two years she had pain on and off. During her fourth pregnancy it became worse than ever. After her delivery she called her doctor's attention to her undiminished size, but no notice was taken of her condition. She gradually got bigger until a year and a half ago, when the pain became very severe and lasted a fortnight, and she then took to wearing a belt. This pain was attributed to inflammation of the liver. She continued to increase in size until two months back, when she had another attack of pain, and was laid up for a month. She then became dissatisfied and decided to come to town for further advice. Examination disclosed a swelling filling the abdomen,

and rather inclined to the right side. The tumour, which was very tense, reached to the diaphragm, where it was evidently adherent, as well as to the abdominal walls. Fluctuation could be made out, and there was resonance in the left loin, and in the iliac region, and far back in the right loin. The uterus was retroflexed, with the cyst well above it.

The diagnosis was: "Tumour of the right ovary; adherent."

The operation was very severe, the cyst being universally adherent. It was removed with much difficulty, the patient being greatly collapsed at the finish. Drainage was employed. The drainage-tube was removed on the fifth day. Flatus passed sixty-three hours after the operation. Highest temperature recorded 101·6°.

The patient made a good recovery, and is now alive and well.

46

A. H., a dark-haired, thin-faced woman, aged twenty-nine, married, one child two years and two months old, was seen by me in November 1894. Menstruation was somewhat irregular, and she suffered from dysmenorrhœa before her marriage. In June 1894, she was seized with severe pain in the left side, and sickness. In July she had a similar attack, followed six weeks later by another one, and since then the same kind of attack had occurred

every fortnight. She had also felt movements in her abdomen for some months past.

Examination revealed a swelling, which reached to the ensiform cartilage. There was free fluctuation, no contraction, and no souffle. The lower portion of the tumour pulsated. There was dulness in the centre of the abdomen, and resonance in both flanks, and in the epigastric region. The uterus, which was retroverted and movable, was behind the tumour; the cervix was split. A hard nodule could be felt in the right fornix.

The operation was simple, there being no adhesions.

Flatus passed twenty-four hours after the operation. The highest temperature recorded was 99°.

The patient made a rapid recovery, and is now in good health. 1896.

47

In December 1894, I was asked by Dr. Colvin Smith to see an old woman, who had a swelling in her abdomen, and who complained of pain and tenderness in her right iliac region. The patient was a widow, aged sixty-four, about four feet six inches in height, well nourished, and extremely active for her years. She had had fourteen pregnancies, her youngest child being then nineteen years of age.

Her condition was as follows: No loss of flesh, appetite good, bowels regular, urine acid, sp. gr. 1030,

no albumen or sugar. Skin dry and leathery, heart's action weak, no murmur; pulse 120; temperature 100°. Arcus senilis well marked.

Her abdomen was enlarged on the right side by a swelling which occupied the iliac, lumbar, umbilical, and hypogastric regions. There was dulness over the tumour, and some tenderness on touch. Deep pressure gave rise to much pain. The tumour was very tense, and fluctuation was not evident, though bimanually an indistinct wave was now and again detected. Examination per vaginam revealed the uterus high up behind the tumour, which seemed to be closely connected with the body of that organ. The cervix could be pushed upwards, but no lateral movement could be made, even with the help of the sound, which passed into the uterine cavity to the extent of two inches. The diagnosis arrived at was: "Ovarian tumour, probably dermoid, involving the right broad ligament."

On January 5, 1895, Dr. Dickson administered gas and ether, and assisted by my colleague, Mr. Charles Morris, I proceeded to remove the tumour. On opening the abdomen the omentum was found to be adherent to the parietal peritoneum, and the incision had to be prolonged. The adhesions extended to the top of the bladder, but were easily broken down. It was then seen that the inner surface of the omentum was adherent all over the front of the tumour, necessitating a tedious process of peeling off, clamping, and ligaturing of the bleeding points.

The tumour was so embedded in adherent intestine, both large and small, that only its anterior surface was then exposed. A small trocar was pushed through the cyst-wall, but only a few ounces of thick dermoid fluid escaped. Sponges were then carefully packed around the opening, and the cyst incised, the immediate result being a rush of thick, yellow fluid, and pea-like bodies, which spurted out over the mackintosh sheeting, giving one the idea of the bursting of a pease-pudding. Meanwhile the tumour had been drawn forward, the edges of the incision being held open by forceps, and the rest of the contents, which included two bundles of dark hair, was squeezed out. The opening in the cyst was then temporarily closed, and the *débris* cleared away, the sponges being at the same time withdrawn. The emptied cyst was then brought to the surface, and the adherent intestines detached from its upper and back portions. The cæcum and appendix were next separated, and the pelvic adhesions broken down. Notwithstanding the large extent of intestinal adhesions, it was observed that the contents of the cyst were quite free from smell. The pedicle displayed most unusual appearances. It was about four inches long, very narrow, and loosely twisted from without inwards, or from right to left, to a point midway in its length. At this point a tough intestinal adhesion had almost encircled it, and could only be detached by careful dissection. Below this point the pedicle was twisted from within outwards, or from left to

right; that is to say, in the opposite direction to the twist on the outer half of the pedicle. The only explanation of this unusual condition would seem to be that the pedicle had first become loosely twisted in its whole length, and then, during some local attack of inflammation the intestine had become adherent, thus holding the pedicle at that point, and that at some subsequent date, the outer part of the pedicle had become untwisted, and later on the tumour had rotated in the reverse direction, and had then become fixed, its vitality being maintained by the omental and other adhesions. The pedicle was next transfixed, tied, and divided, and the many bleeding points secured. Owing to the extensive adhesions, there was a fair amount of blood in the abdominal and pelvic cavities, and the sponging-out occupied a considerable time. Flushing was not resorted to, but drainage was employed. The wound was then closed with silkworm-gut sutures, and covered with simple gauze dressings.

The patient made a rapid and complete recovery, and is now in perfect health.

The cyst and contents were shown at the meeting of the Obstetrical Society in February 1895, and the specimens are now in the Museum of the Royal College of Surgeons.

48

L. C., a dark-haired, full-faced woman, aged thirty-seven, married, no family, came under my notice in

January 1895. The menstrual history was quite natural. For three years she had suffered from bearing-down pains and had felt pain in her abdomen up to three weeks back. Since that time these pains had quite ceased, but she was emaciating rapidly and the veins of the right leg had become enlarged.

On examination, a central swelling was found with free fluctuation in it; no pulsation. There was dulness all over the lower part of the abdomen, and resonance in both flanks, and above the umbilicus. The tumour was in front of and above the uterus.

The operation was fairly simple. The tumour burrowed in the left broad ligament and had to be enucleated. No drainage was employed.

Flatus passed forty-eight hours after the operation. The highest temperature recorded was 101·2°.

49

Clinical Observations on a Case of Axial Rotation of an Ovarian Tumour.

In May 1895, a woman aged fifty, was admitted into the Samaritan Free Hospital for Women under my care. She had an abdominal tumour, and was emanciating rapidly. On examination, a large movable swelling was found, somewhat inclined to the left of the middle line and reaching to the umbilicus. On its left side there was a protuber-

ance easily definable through the abdominal wall. Per vaginam, the lower part of the growth could not be made out, even on firm pressure from above. I asked a senior colleague to see the patient with me, and he was struck with the extreme mobility of the tumour, and also with the fact that it could not be felt from the vagina. He pointed out, however, that the protruding lump was on the right side of the swelling, and not on the left, as I had stated. Next day I examined the patient again, and found the protuberance in its original position on the left side of the tumour, and was satisfied that some mistake had been made as to the exact location of the irregular portion of the growth.

Two days later, the patient told me that she had had a sore, dragging sort of pain in the left side for some hours, but it was not bad enough to complain of at the time. On palpating her abdomen the swelling was found to be much altered in shape, and the protuberance could not be felt on either side. Per vaginam, the base of the tumour was well down in the pelvis, and bimanually fluctuation could easily be detected. The uterus was behind the cyst, and was freely movable. Whilst examining the patient, I purposely pushed the tumour up out of the pelvis, and almost immediately the outline of the protuberance appeared on her right side, and moved quickly across her abdomen to the left iliac region. I made a note of the occurrence, and whilst thinking the matter over, the patient's abdomen being uncovered,

and she lying on her back, I was surprised to see the protuberance wandering slowly back across the abdomen from left to right. A few minutes later, on examining per vaginam, I found the base of the tumour well within reach of the finger, and no "protuberance" to be felt on either side. It was evidently an ovarian tumour with a long pedicle, twisting from without inwards, or from left to right. On the following morning the patient's abdomen was opened and the cyst emptied. On withdrawing it a long thick pedicle was found, twisted with three half turns from without inwards, or from left to right, not strangulating the pedicle, but allowing the vessels to pulsate freely. On the left side of the tumour was a small cyst or loculus, about the size of a hen's egg, containing thick dermoid-like fluid. The tumour was a papillomatous cystoma. The patient is now in perfect health.

50

M. G., a merry-faced woman of medium height, aged forty-one, married, no family, was seen by me in May 1895. For some years she had been suffering from abdominal pains and backache. Examination revealed the uterus in front of the swelling.

On opening the abdomen, the tumour was found to be closely attached to the back of the uterus, behind the peritoneum and extending into the broad ligament on the left side. As it seemed impossible

to remove it, a small quantity of clear fluid was withdrawn by a hypodermic syringe, and the abdomen closed. Both ovaries were normal. The patient recovered rapidly. When last seen in 1896, the swelling was very much smaller and causing no trouble of any kind.

51

B. H., a thin, sallow-featured woman, aged fifty, married, one child sixteen years of age, came for advice in April 1895.

Menses appeared at the age of fourteen and were painful, with medium loss. The last period occurred four years back. In August 1894, she first noticed a swelling in her abdomen, and attributed it to a fall she had had four years before, when she injured both her breast and abdomen.

Examination disclosed a swelling reaching to the ensiform cartilage. There was dulness over the front and to the right of the tumour, and resonance in the left flank. Fluctuation was very distinct; no crepitation; no impulse. The uterus was pushed to the left by the swelling, which was closely attached to the cervix, both tumour and uterus moving together.

The cyst was adherent to the abdominal walls in front. It contained twelve pints of dark thick fluid. The pedicle was broad and very short. A drainage-tube was kept in for twenty-four hours.

Flatus passed fifty hours after the operation. The highest temperature recorded was 100·2°.

The patient made a rapid recovery and is now well.

52

A. P., a tall, brown-haired, very stout woman, aged thirty-three, single, was seen by me in June 1895.

Menses appeared at the age of fourteen; the flow, which was free, lasting four days. Of late it had lasted seven days, and the loss was greater. For five years she had been troubled with sickness from time to time, and during the last twelve months had noticed her abdomen getting bigger, but found that at the same time she was losing flesh in the upper part of her body and in her limbs. On examination the abdomen was found to be evenly distended by a swelling reaching half way to the ensiform cartilage. There was dulness all over the front of the abdomen, but resonance in both flanks. No free fluctuation could be detected. The tumour could be felt behind the uterus, which was pushed slightly towards the left side.

The operation was simple. The tumour, which was on the right side and burrowed in the broad ligament, was enucleated, twelve pints of clear fluid having been withdrawn. Drainage was not employed.

Flatus passed fifty hours after the operation. Highest temperature recorded 100·4°.

The patient recovered and is now in good health.

53

E. P., a thin, sallow, tubercular-looking woman, aged nineteen, single, came for advice in June 1895. She first menstruated at the age of thirteen, and was quite regular for two years. Since then the periods occurred every fourteen days, with free loss, the flow lasting from five to six days, but being painless. She had been quite well up to two months before her visit, when she first noticed her abdomen begin to enlarge, though she was unable to say on which side, but she felt pain first in the right side, and latterly in the left iliac region also, the pain being of an intermittent character. She was also suffering from an attack of acute bronchitis at the time of her first visit.

The abdomen was found to be equally distended; fluctuation free; no pulsation; resonance in the right flank, and dulness elsewhere. When again examined on July 2, this condition was found to be reversed, thus leading me to diagnose twisted pedicle. The tumour was an ovarian cystoma of the right side, the pedicle being twisted one half turn from within outwards, or from left to right. The operation, though short, caused great shock, and the patient was much collapsed for an hour

afterwards, but she rallied and made a rapid recovery, and had no return of the bronchitis.

Flatus passed fifty-six hours after the operation. The highest temperature recorded was 102°.

She is now in perfect health.

54

E. H., aged thirty, widow, has had two children, the youngest child being six years of age.

She first came under my notice in October 1895. Menses appeared at the age of thirteen, irregularly for some time, the flow lasting four days with free loss. For the last three years she had varicose veins in the right leg, and complained of pain and movements in her abdomen, which gave rise to a feeling of soreness in the right side, particularly when getting in and out of bed.

A small round swelling was found in the right iliac region, tense, painful, and unusually free in its movements, suggesting a long pedicle. The diagnosis arrived at was: Dermoid of the right ovary with twisted pedicle.

The operation was perfectly simple. The rotation was from without inwards, or from right to left. No flushing or drainage was employed.

Flatus passed fifty-two hours after the operation. The highest temperature recorded was 102·2°.

TABLE OF CASES

No.	Name.	Age.	Condition.	Residence.	Medical Attendant.	Disease.	Side.
1	J. M.	62	W	Finsbury	Dr. Goodsall	Cystoma	Right
2	M. W.	38	M	Battersea	Dr. Tandy	Multilocular	Both
3	F. H.	28	S	Westminster	Dr. Pearce	Cystoma	Left
4	S. W.	29	S	Putney	Dr. Jeaffreson	Multilocular	Left
5	G. C.	61	M	Fulham	Mr. Butler-Smythe	T. in B. L.	Left
6	G. W.	41	W	Chelsea	Dr. Stretton	Multilocular	Both
7	M. W.	43	M	Kennington	Dr. Jones	Papilloma in B. L.	Right
8	A. A.	50	M	Camberwell	Mr. Butler-Smythe	Papilloma in B. L.	Right
9	J. R.	33	S	Westminster	Dr. Folwell	Dermoid	Right
10	G. S.	40	S	Westminster	Dr. Owen	T. in B. L.	Left
11	A. B	42	W	Clapham	Dr. Williams	Double cystoma	Both
12	J. R.	34	S	Westminster	Dr. Folwell	Dermoid	Left
13	A. M.	50	M	Kennington	Mr. Butler-Smythe	T. in B. L.	Left
14	M. P.	61	W	Lambeth	Dr. Tandy	T. in B. L.	Right
15	C. D.	39	W	London	Dr. Stretton	Cystoma	Right
16	A. W.	23	M	Essex	Dr. Wright	Cystoma	Right
17	S. W.	60	W	W. London	Dr. Squire	Multilocular	Left
18	M. B.	44	W	Westminster	Dr. Steavenson	T. in B. L.	Right
19	G. F.	28	S	Torquay	Dr. Crane	Double cystomata	Both
20	M. D.	50	M	Sussex	Dr. Gasquet	T. in B. L.	Left
21	M. S.	18	S	Essex	Dr. Haynes	Double cystomata	Both
22	J. N.	71	W	Battersea	Dr. Tandy	Multilocular	Left
23	M. T.	24	M	Somerset	Mr. Roe	Cystoma	Left
24	C. L.	34	M	Essex	Mr. Wallis	Dermoid	Left
25	B. A.	28	M	Kent	Dr. Savory	Cystoma	Right
26	M. T.	50	M	Islington	Dr. Stevens	Double dermoid	Both
27	A. E.	26	S	Westminster	Dr. Smallpiece	Tubo-ovarian	Right
28	H. C.	28	S	Windsor	Dr. Gooche	Cystoma	Right

Adhesions.	Pedicle.	Drainage.	Date.	Result.	Remarks.
Par. pelv.	Broad	—	Sept. 13, 1882	Recovered	*Lancet*, vol. i. p. 270, 1883. Alive in 1890.
Par. int.	Broad	—	Feb. 6, 1883	do.	*Lancet* 1883, vol. ii. p. 494. Alive and well 1896.
Par. pelv.	Soft	—	Jan. 16, 1884	do.	*B. M. J.* vol. i. 1888. Died two years later.
Universal	Thin	Drained	Sept. 6, 1885	Died	Fourteen days septic when operated on. Died.
—	Thin	—	March 20, 1886	Recovered	Enucleation. In good health 1892.
None	Thin	—	April 8, 1886	do.	Simple. Alive and well 1894.
Universal	—	Drained	Sept. 16, 1886	do.	Enucleation. *J. M. S.* July 1893. In good health 1896.
Parietal	—	Drained	Nov. 11, 1886	do.	Enucleation. Papilloma over pelvic contents. Died 3 years later.
None	T. P.	—	Jan. 22, 1887	do.	*B. M. J.* vol. ii. p. 1008, 1890. Alive and well 1896.
Par. pelv.	—	Drained	Feb. 10, 1887	do.	Enucleation. Alive and well 1896.
None	—	—	April 15, 1887	do.	Simple. Alive and well 1893.
None	—	—	Jan. 3, 1888	do.	Simple. *B. M. J.* vol. ii. 1890. Alive and well 1896.
Universal	—	Drained	July 16, 1888	do.	Enucleation. 14 pints. Alive and well 1891.
—	—	Drained	July 27, 1888	do.	Enucleation. Alive and well 1894.
Intestinal	Broad	—	Feb. 25, 1889	do.	Simple. Alive and well 1892.
—	—	—	April 25, 1889	do.	Simple. Alive and well 1896.
Parietal	B. T.	Drained	Feb. 24, 1890	do.	Simple. Alive and well 1896.
Parietal	—	Drained	April 20, 1890	do.	Enucleation. Alive and well 1896.
None	—	—	May 9, 1890	do.	Simple. Alive and well 1896.
Universal	—	Drained	June 20, 1890	do.	Enucleation; 15 pints; gelatinous. Alive and well 1896.
—	—	—	Sept. 10, 1890	do.	Simple. Alive and well 1896.
None	S. P.	—	Oct. 22, 1890	do.	Colloid contents. Alive and well 1894.
Parietal	—	Drained	March 24, 1891	do.	Simple. Alive and well 1895.
Pelvic	T. P.	—	July 30, 1891	do.	In 4th month of pregnancy, Alive and well 1896.
None	T. P.	—	Oct. 9, 1891	do.	Simple. Alive and well 1895.
Universal	T. P.	Drained	Nov. 3, 1891	do.	Difficult. Alive and well 1896.
Int. pelv.	—	—	Nov. 26, 1891	do.	Simple. Alive and well 1896.
Universal	T. P.	Drained	Dec. 15, 1891	do.	Ruptured cyst; difficult. Alive and well 1896.

No.	Name.	Age.	Condition.	Residence.	Medical Attendant.	Disease.	Side.
29	G. D.	31	M	London	Dr. Gibbons	Cystoma	Right
30	E. W.	24	M	Norfolk	Dr. Seccombe	Dermoid	Left
31	S. T.	51	M	Fulham	Dr. Painton	Cystoma	Right
32	J. D.	32	M	Kensington	Dr. Ensor	Double dermoid	Both
33	M. W.	57	M	London	Dr. Nix	Papilloma	Right
34	E. W.	25	M	Norfolk	Dr. Seccombe	Cystoma	Right
35	E. L.	16	S	London	Mr. Murray	Cystoma	Left
36	R. M.	27	W	Westminster	Mr. Butler-Smythe	Cystic ovaries	Both
37	E. L.	35	S	Kensington	Mr. Butler-Smythe	Cystic ovaries	Both
38	E. W.	22	S	London	Dr. Tanner	Cystoma	Right
39	E. R.	29	M	Battersea	Dr. Brinton	Tubo-ovarian	Right
40	E. P.	58	M	Westminster	Dr. Brinton	Cystic sarcoma	Right
41	E. C.	50	M	Westminster	Mr. Butler-Smythe	Cystoma	Right
42	M. A.	35	M	Battersea	Dr. Macrory	T. in B. L.	Left
43	S. P.	42	S	Vauxhall	Dr. Weir	Double dermoid	Both
44	A. S.	28	S	London	Dr. Nix	Cystoma	Right
45	G. D.	42	M	Sandhurst	Dr. Russell	T. in B. L.	Right
46	A. H.	30	M	Leicester	Dr. Coles	Cystoma	Right
47	J. S.	68	W	London	Dr. Colvin Smith	Dermoid	Right
48	L. C.	40	M	Kent	Dr. Lynn	B. L. T.	Left
49	E. B.	50	W	London	Dr. Fleury	Multilocular	Left
50	M. G.	41	M	London	Dr. May	B. L. T.	Right
51	B. H.	42	M	London	Mr. Butler-Smythe	Multilocular	Right
52	A. P.	32	S	London	Dr. H. Roberts	Para-ovarian	Right
53	E. P.	19	S	Deal	Mr. Butler-Smythe	Multilocular	Right
54	E. H.	30	W	London	Dr. Nariman	Dermoid	Right

Adhesions.	Pedicle.	Drainage.	Date.	Result.	Remarks.
Pelvic	—	Drained	March 8, 1892	Recovered	Tubal pregnancy left side. *J. M. S.* July 1894. Alive and well 1896.
Universal	T. P.	Drained	May 6, 1892	do.	34 pints; cyst 4 lb. *B. M. J.* June 1894. Alive and well 1896.
Universal	T. P.	—	June 28, 1892	do.	13 pints. Alive and well 1896.
Universal	T. P.	Drained	July 7, 1892	do.	*B. M. J.* April 1893. Alive and well 1896.
None	V. B.	—	July 11, 1893	do.	Simple; 8 pints. Alive and well 1895.
Universal	—	Drained	Oct. 6, 1893	do.	30 pints; *B. M. J.* June 1894. Alive and well 1896.
—	—	—	Dec. 1, 1893	do.	Simple. Alive and well 1896.
Pelvic	—	Drained	Dec. 14, 1893	do.	Simple. Alive and well 1896.
—	—	—	Jan. 2, 1894	do.	Simple. Alive and well 1896.
Parietal	—	—	Jan. 29, 1894	do.	Simple; 18 pints. Alive and well 1896.
Pelvic	—	Drained	Feb. 27, 1894	do.	Difficult. Alive and well 1896.
Par. int.	—	Drained	June 5, 1894	do.	Difficult. Alive and well 1896.
Pelv. int.	V. B.	Drained	July 12, 1894	do.	15 pints; cyst 8 lb. Alive and well 1896.
Universal	—	Drained	July 27, 1894	do.	Incomplete; 12 pints. Alive and well 1896.
Par. int. pelv.	T. P.	Drained	Oct. 5, 1894	do.	14 pints. Died 1895.
Om. pelv.	—	—	Oct. 20, 1894	do.	Simple; 8 pints. Alive and well 1895.
Universal	—	Drained	Oct. 27, 1894	do.	Enucleation. Alive and well 1896.
None	—	—	Nov. 28, 1894	do.	Simple. Alive and well 1896.
Par. om. pelv.	T. P.	Drained	Jan. 5, 1895	do.	Pints of pill-like masses. *Obs. Soc. Trans.* 1895. Alive and well 1896.
—	—	—	Jan. 19, 1895	do.	Enucleation. Alive and well 1896.
None	T. P.	—	May 9, 1895	do.	Simple. Alive and well 1896.
—	—	—	May 21, 1895	do.	Incomplete. In good health 1896.
Parietal	T. P.	Drained	May 22, 1895	do.	Simple. Alive and well 1896.
None	—	—	June 11, 1895	do.	Enucleation. Alive and well 1896.
None	T. P.	—	July 5, 1895	do.	Simple. Alive and well 1896.
None	T. P.	—	Oct. 30, 1895	do.	Simple. Alive and well 1896.

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